# MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (130) Reg. Dist. No. 9

## CERTIFICATE OF DEATH

26600

**1. PLACE OF DEATH:**

(a) County Allegany

(b) City or town Frostburg (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: Miners Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-4-39 to 7-7-39

(e) Length of stay in this community (yrs., mos., or days) 38

**2. HOME (USUAL RESIDENCE) OF DECEASED:**

(a) State Md (b) County Allegany

(c) City or town Frostburg Rural (If outside city or town limits, write RURAL and give town)

(d) Street No. Hatchtown (If rural give location)

(e) If foreign born, how long in U. S. A.? _____ years

3 (a) **FULL NAME** Horace Anderson

3 (b) If veteran, name war —

3 (c) Social Security No. 220-10-9372

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Margaret Fowler

6. (c) If alive, give age 37 years

7. Birth date of deceased (mo., day, yr.) May 30-1901

8. AGE: Years 38 | Months 1 | Days 7 | If less than one day _____ hr. _____ min.

9. Birthplace Garrett Co. Md (Town, county, and state)

10. Usual occupation laborer

11. Industry or business W.P.A.

FATHER 12. Name Reed Anderson

13. Birthplace Md.

MOTHER 14. Maiden Name Viola Fazenbaker

15. Birthplace Md.

16 (a) Informant Harry Fuller Jr.

(b) Address Frostburg Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 9-39 (month) (day) (year)

(c) Cemetery or crematory Bloomer Dem.

Location Garrett Co

18 (a) Funeral director J. J. Hurst

(b) Address Frostburg

19 (a) 7-8-39 (Date rec'd by registrar) (b) Mrs. A. R. Walker Registrar

**MEDICAL CERTIFICATION**

20. Date of death July 7 1939, at 1:40 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from July 4 1939, to July 7 1939; and that I last saw him alive on July 7 1939.

| | Duration |
|---|---|
| Immediate cause of death acute nephritis following | 48 hours. |
| Due to gastro-enteritis. | 4 days. |
| Due to | |
| Other conditions Mal-nutrition | |

(Include pregnancy within 3 months of death)

Major findings:

Of operations none

Of autopsy —

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature H. C. Diehl M.D. (M. D. or other)

Address Frostburg, Md Date signed 7-8-39

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

RECEIVED
AUG 2 1939
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore

Reg. Dist. No. 9

## CERTIFICATE OF DEATH

06601

VS. A15 MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**

(a) County Allegany

(b) City or town Zihlman Md.
(If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: —

(d) Length of stay in hospital or inst. (yrs., mos., or days) —

(e) Length of stay in this community (yrs., mos., or days) Lifetime

**2. HOME (USUAL RESIDENCE) OF DECEASED:**

(a) State Md (b) County Allegany

(c) City or town Zihlman Md
(If outside city or town limits, write RURAL and give town)

(d) Street No. —
(If rural give location)

(e) If foreign born, how long in U. S. A.? — years

3 (a) **FULL NAME** Thomas Anderson

| 3 (b) If veteran, name war | 3 (c) Social Security No. |
|---|---|
| — | — |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed or divorced. |
|---|---|---|
| Male | White | Widowed |

6 (b) Name of husband or wife Mary Plummer

6. (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Feb 27, 1853

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 86 | 4 | 16 | — hr. — min. |

9. Birthplace Eckhart Md.
(Town, county, and state)

10. Usual occupation Miner

11. Industry or business Coal Mines

FATHER 12. Name James Anderson

13. Birthplace Unknown

MOTHER 14. Maiden Name Delilah Porter

15. Birthplace Unknown.

16 (a) Informant Mrs. Chas. Filer

(b) Address Mather, Pa

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 15 1939 (month) (day) (year)

(c) Cemetery or crematory Allegany Cemetery

Location Frostburg, Md.

18 (a) Funeral director Jacob Hafer

(b) Address Frostburg Md.

19 (a) 7-15-39 (Date rec'd by registrar) (b) mrs. A.R. Walker Registrar

**MEDICAL CERTIFICATION**

20. Date of death July 13 1939, at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 12 1939, to 7-13 1939 and that I last saw him alive on 7-12 1939.

| Immediate cause of death | Duration |
|---|---|
| Cardiac Dilatation | |
| Due to Chronic myocarditis | |
| Due to Hypostatic pneumonia | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings:

Of operations —

Of autopsy —

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence —

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury —

23. Signature J E Cooley M.D. (M. D. or other)

Address Frostburg Md. Date signed 7-13-39

RECEIVED
AUG 3 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

06602

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County ALLEGANY
City or town CUMBERLAND (If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: MEMORIAL HOSPITAL
Stay in hospital or inst. (yrs., or mos., or days) 2 DAYS
Stay in this community (yrs., or mos., or days) 50 years

**2. USUAL RESIDENCE (HOME) OF DECEASED:** (For newborn infants give residence of mother)
State MARYLAND County ALLEGANY
City or town CUMBERLAND Ward No. (If outside city or town limits, write RURAL NEAR and give town)
Street No. 517 FORESTER AVE. (If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** MRS. ANNA BELL

**3. (b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| FEMALE | WHITE | MARRIED |

B (b) Name of husband or wife MR. WILLIAM H. BELL
6(c) If e1ive, give age 68 years

7. Birth date of deceased (mo., day, yr.) JULY 18, 1871

8. AGE:

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 68 | 0 | 2 | ____hrs. ____min. |

9. Birthplace Frostburg, MD. (Town, county, and state)
10. Usual occupation HOUSEWIFE
11. Industry or business
FATHER 12. Name GODFREY FAZENBAKER
13. Birthplace MARYLAND
MOTHER 14. Maiden name GEORGANNA BUTT
15. Birthplace MARYLAND
16. Informant Memorial Hospital
Address Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 22, '39 (month) (day) (year)
Cemetery or crematory Philos Cemetery
Location Westernport, Maryland
18. Funeral director Louis Stein, Inc.
Address Cumberland, Maryland

19. July 20, 1939 J. L. Franklin, M.D.
(Date recd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 20, 1939, at 12:45 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 17, 1939, to July 19, 1939, and that I last saw h[illegible] alive on July 19, 1939.

| | DURATION |
|---|---|
| Immediate cause of death Duodenal ulcer | 2 yrs. |
| Due to | |
| Due to | |
| Other conditions Hemorrhage from ulcer (Include pregnancy within 3 months of death) | 1 wk. |

Major findings:
Of operations none
Of autopsy no autopsy

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE D. B. Jones M.D.
M. D. or other
Address Medical Bldg Date signed 7/20/39

RECEIVED
AUG 7 1939
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1602)

## CERTIFICATE OF DEATH

06603

Reg. Dist. No. 8

**1. PLACE OF DEATH:**

County Allegany

City or town Lonaconing, Md
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:
Douglas ave.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Lonaconing Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. Douglas Ave.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR —

**3. (a) FULL NAME** "Baby" Boetcher

**3. (b) Social Security Number** —

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | child |

6 (b) Name of husband or wife —

6(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 6th 1939

**8. AGE:**

| Years | Months | Days | If less than one day |
|---|---|---|---|
| — | — | 2 | 12 hrs. — min. |

9. Birthplace Lonaconing, Md
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER
12. Name John Boetcher
13. Birthplace Lonaconing, Md

MOTHER
14. Maiden name Isabelle Getson
15. Birthplace Lonaconing, Md

16. Informant John Boetcher
Address Lonaconing, Md

17. Buried Date thereof July 9. 1939
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Oak Hill Cemetery

Location Lonaconing, Md

18. Funeral director M. Eichhorn

Address Lonaconing, Md

19. July 9- 1939 Dr. E. Pon Taylor
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 9th 1939, at 12:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased ~~from~~ at about 8 P.M. to July 8 1939, and that I last saw ~~him~~ alive on July 8 1939.

| Immediate cause of death | DURATION |
|---|---|
| Central Hemorrhage | |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE R. M. Shelton Jr. M. D. ~~or other~~

Address Midland, Md Date signed 7-12-39

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

RECEIVED
AUG 7 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

06604

Reg. Dist. No. 4

**1. PLACE OF DEATH:**
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 11 East Street
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 50 years

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 11 East Street
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

**3. (a) FULL NAME:** William Albert Brant

**3. (b) Social Security Number:**

**4. Sex:** Male

**5. Color or race:** White

**6.(a) Single, married, widowed, or divorced:** Married

6 (b) Name of husband or wife: Effie M. Wolford

6(c) If alive, give age: 69 years

**7. Birth date of deceased (mo., day, yr.):** April 12, 1866

**8. AGE:** Years: 73 Months: 3 Days: 0 If less than one day: hrs. min.

9. Birthplace: Hazen, Maryland
(Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business: April, 1936

FATHER
12. Name: George Brant
13. Birthplace: Maryland

MOTHER
14. Maiden name: Julian Oster
15. Birthplace: Pennsylvania

16. Informant: Mrs. Effie Brant
Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 14, 39 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Cumberland, Maryland

18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Maryland

19. June 13 19 39 (Date rec'd by registrar) Jos. S. Franklin M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: July 12, 39, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from About May 1935, to July 12 1939, and that I last saw h alive on July 11 1939.

Immediate cause of death: Hypostatic Pneumonia — Duration: 1wk

Due to: Cerebral Arteriosclerosis — Duration: 6yrs

Due to: Broncho-pneumonia. Sudden. — Duration: two days.

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

DURATION

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Arthur T. Bowles M. D. M. D. or other
Address: 40 N. Liberty St. Date signed 7-13-39

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
AUG 7 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

(3)

06607

Reg. Diat. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County ALLEGANY
City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
MEMORIAL HOSPITAL
Stay in hospital or inst. (yrs., or mos., or days) 0
Stay in this community (yrs., or mos., or days) 0

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State MARYLAND County ALLEGANY
City or town CUMBERLAND Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 213 BEDFORD ST., CITY
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME**
BABY BOY CAMPBELL (STILLBORN)

**3. (b) Social Security Number**

| 4. Sex | 5. Color or race | 6. (a) Single, married, widowed, or divorced |
|---|---|---|
| MALE | WHITE | SINGLE |

6 (b) Name of husband or wife
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 19, 1939

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| STILLBORN | | | 0 hrs. 0 min. |

9. Birthplace MARYLAND (Town, county, and state)
10. Usual occupation --
11. Industry or business --

FATHER
12. Name ROBERT R. CAMPBELL
13. Birthplace MARYLAND

MOTHER
14. Maiden name THELMA E. ELLIOTT
15. Birthplace PENNA.

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 20, 1939 (month) (day) (year)
Cemetery or crematory Greenmont Cemetery
Location Cumberland, Maryland
18. Funeral director Louis Stein, Inc.
Address Cumberland, Maryland

19. July 20, 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH JULY 19, 1939, at 9:25 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 19 1939, to July 19 1939, and that I last saw alive on JULY 19, 1939

| Immediate cause of death | DURATION |
|---|---|
| Rupture, separation of placenta. | |
| Due to ? | |
| Due to | |
| Other conditions | |

(Include pregnancy within 8 months of death)

Major findings:
Of operations
Of autopsy None

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. P. Hodgson Jr. M.D.
Address Cumberland, Md. M. D. or other
Date signed 7/20/39

RECEIVED
AUG 7 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

06605

Reg. Dist. No. 4

**1. PLACE OF DEATH:**
County: ALLEGANY
City or town: CUMBERLAND, MD.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: MEMORIAL HOSPITAL
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days):

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: PENNSYLVANIA County:
City or town: SAND PATCH Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.:
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: ✓

**3. (a) FULL NAME:** MR. CLAUDE CANNON

**3. (b) Social Security Number:**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| MALE | WHITE | SINGLE |

6 (b) Name of husband or wife:
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): OCT. 18, 1920

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 18 | 8 | 21 | hrs. min. |

9. Birthplace: PENNSYLVANIA
(Town, county, and state)

10. Usual occupation: STUDENT

11. Industry or business:

FATHER 12. Name: WILLIAM CANNON
13. Birthplace: PENNA.

MOTHER 14. Maiden name: JEANETTE SECRIST
15. Birthplace: PENNA.

16. Informant: BARBARA CANNON
Address: MEMORIAL HOSPITAL

17. (Burial, cremation, or removal. Which?) Meyersdale, Pa. Date thereof July 12, 1939 (month) (day) (year)
Cemetery or crematory: White Oak Cem
Location: Larimer Township - Rt*3, Meyersdale, Pa.

18. Funeral director: Miller Rose Price
Address: Meyersdale, Pa.

18 July 10 19 39 J. L. Franklin, M.D.
(Date rec'd by registrar) Registrar

DR. W. F. WILLIAMS

## MEDICAL CERTIFICATION

20. DATE OF DEATH: JULY 9, 1939 19 12:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-8- 1939, to 7-9- 1939, and that I last saw him alive on 7-8-39 19

Immediate cause of death: Chronic Nephritis (Uremia) — DURATION: 4 hrs

Due to:

Due to:

Other conditions:
(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: W. F. Williams M. D. or other
Address: Cumberland Date signed 7-9-39

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
AUG 7 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH
Bureau of Vital Statistics, Baltimore (210-m)
Reg. Dist. No. 4

# CERTIFICATE OF DEATH

06606

**1. PLACE OF DEATH:**
(a) County Allegany
(b) City or town Cumberland (If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: Allegany Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 31 days
(e) Length of stay in this community (yrs., mos., or days)

**2. HOME (USUAL RESIDENCE) OF DECEASED:**
(a) State Md. (b) County Allegany
(c) City or town McCoole (If outside city or town limits, write RURAL and give town)
(d) Street No. McCoole Hill (If rural give location)
(e) If foreign born, how long in U. S. A.? ____ years

3 (a) **FULL NAME** Frank Chucci

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6. (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Aug. 5, 1912

8. AGE: Years 26 | Months 11 | Days 3 | If less than one day ____ hr. ____ min.

9. Birthplace Henry, W. Va. (Town, county, and state)

10. Usual occupation Clerical Employee

11. Industry or business

FATHER 12. Name Mike Chucci
FATHER 13. Birthplace Italy

MOTHER 14. Maiden Name Josephina Pailuchi
MOTHER 15. Birthplace Italy

16 (a) Informant Father, Mike Chucci
(b) Address McCoole, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-11-39 (month) (day) (year)
(c) Cemetery or crematory St. Thomas
Location Keyser, W. Va.

18 (a) Funeral director M. L. Rogers Funeral Home
(b) Address Keyser, W. Va.

19 (a) July 10 1939 J. T. Franklin, M. D. (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. Date of death July 8 1939, at 8:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/1/39 19__, to 7/8/39 19__, and that I last saw him alive on 7/8/39 19__.

Immediate cause of death Broken back

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

| Duration |
|---|
| |
| |
| |
| |
| |
| |

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 7-2-39
(c) Where did injury occur? Pleasant Valley (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Yes (Specify type of place) While at work? No
(e) Means of injury Auto Accident

23. Signature J. T. Franklin M. D. (M. D. or other)
Address Cumberland Md. Date signed 7/9/39

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

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AUG 7 1939
BUREAU V. S.

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

# CERTIFICATE OF DEATH

(13)

06608

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Williams Boat at Evitts Creek
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Md County Allegany
City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 218 Fulton
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** James Thomas Collins

**3. (b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | Single |

6 (b) Name of husband or wife
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 21, 1931

8. AGE: Years 8 | Months 3 | Days 3 | If less than one day hrs. min.

9. Birthplace Cumberland Md
(Town, county, and State)

10. Usual occupation

11. Industry or business

FATHER 12. Name James Carl Collins
13. Birthplace Cumberland

MOTHER 14. Maiden name Hazel Katherine Haines
15. Birthplace Keyser W Va.

16. Informant James Collins
Address 218 Fulton St Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 26/939 (month) (day) (year)
Cemetery or crematory Million Sub Sta
Location Keyser W Va.
18. Funeral director Jacob Taper
Address Cumberland Md

19. July 26 39 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 24 1939, at 7:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__, to ____ 19__, and that I last saw h__ alive on ____ 19__.

| Immediate cause of death | DURATION |
|---|---|
| accidental drowning | |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings:
Of operations —
Of autopsy None

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, ~~suicide~~, or ~~homicide~~ accident Date of 7-24-1939
Where did injury occur? New Cumberland (City or town) Allegany (County) Md (State)
Injured at home, farm, industry, public place (where?) Public Place
Means of injury drowning Injured at work? no

23. SIGNATURE James H. Brown, M.D.
M. D. or other
Address Cumberland Md Date signed 7-24-39

Deputy Medical Examiner — Allegany Co.

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WITHIN CORPORATE LIMITS

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(182) CB 06609

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 1300 Bedford St.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days): 1 day

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Penn. County:

City or town: Mt Airy Pa. Ward No. —
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 310 Gowen St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: ✓

**3. (a) FULL NAME:** Edward W. David Jr.

**3. (b) Social Security Number:**

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: —

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): 5-23-1920

**8. AGE:** Years: 19 Months: 1 Days: 19 If less than one day ____ hrs. ____ min.

9. Birthplace: Montclair, New Jersey
(Town, county, and state)

10. Usual occupation: Student at College

11. Industry or business:

FATHER
12. Name: Edward W. David
13. Birthplace: Philadelphia, Pa.

MOTHER
14. Maiden name: Annie Merrill
15. Birthplace: Enosburg Falls, Vermont

16. Informant: W. M. David

Address: 42 W. School Lane, Phila. Pa.

17. Removal. (Burial, cremation, or removal. Which?) Date thereof July 13 39 (month) (day) (year)

Cemetery or crematory: (near Philadelphia)

Location: Penwyd Pa.

18. Funeral director: Louis Stein Inc

Address: Cumberland Md

19. July 17 1939 (Date rec'd by registrar) Jos. P. Frankle, M.D. Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH: July 12th 1939, at 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__, to ____ 19__, and that I last saw h____ alive on ____ 19__.

Immediate cause of death: Suffocation — accidental mechanical suffocation. C.W.S.P.

Due to: Patient's head and face were deeply buried in a pillow, during the height

Due to: of an epileptic seizure.

Other conditions: Epiplepsy — DURATION: 2 yr.

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy: no autopsy

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE: Lynne H. Corson, M.D. M. D. or other

Address: Cumberland, Md. Date signed: 7-13-39

Deputy Medical Examiner - Allegany Co.

VS A15 (I) MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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BUREAU V. S.

WITHIN CORPORATE LIMITS

# MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (131)

Reg. Dist. No. 4

## CERTIFICATE OF DEATH

06610

**1. PLACE OF DEATH:**
(a) County Allegany
(b) City or town Cumberland (If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: 301 Decatur St
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in this community (yrs., mos., or days) 88 yrs

**2. HOME (USUAL RESIDENCE) OF DECEASED:**
(a) State Md (b) County Allegany
(c) City or town Cumberland Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 301 Decatur St (If rural give location)
(e) If foreign born, how long in U. S. A.? ____ years

3 (a) FULL NAME Helen Elliott Deneen

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: John B. Deneen
6. (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Dec 19, 1847

8. AGE: Years 91 | Months 7 | Days 11 | If less than one day ____ hr. ____ min.

9. Birthplace Mt Savage Md (Town, county, and state)

10. Usual occupation Woman Worker

11. Industry or business

FATHER
12. Name Geo Elliott
13. Birthplace Greencastle Pa

MOTHER
14. Maiden Name Susan Fletcher
15. Birthplace Flintstone Md

16 (a) Informant Miss Sophie Deneen
(b) Address 301 Decatur St City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 1/39 (month) (day) (year)
(c) Cemetery or crematory Rose Hill
Location Cumberland Md

18 (a) Funeral director William N. Knight
(b) Address Cumberland Md

19 (a) July 31 1939 (Date rec'd by registrar) (b) H. Franklin M.D. Registrar

## MEDICAL CERTIFICATION

20. Date of death 7/30/39 19____, at 5 a.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/15/39 19____, to 7/29/39 19____, and that I last saw him alive on 7/29/39 19____.

| Immediate cause of death | Duration |
|---|---|
| Chronic Myocarditis | |
| Chronic Nephritis | |
| Due to Uremia & Myocardial | |
| Due to Paralysis | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Richard J. Williams M.D. (M. D. or other)
Address 34 Va. Ave. Cumberland Md Date signed 7/31/39

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

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BUREAU V. S.

WITHIN CORPORATE LIMITS.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (117-C)

## CERTIFICATE OF DEATH

06611

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County: Allegany County
City or town: Cumberland Maryland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Memorial Hospital
Stay in hospital or inst. (yrs., or mos., or days): 3 days
Stay in this community (yrs., or mos., or days):

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Lonaconing Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME:** Mr. George W. Dye

**3. (b) Social Security Number:** None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife: Margaret Clark
6(c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): April 6, 1880

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 58 58 | 3 | 2 | hrs. min. |

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Unemployed

11. Industry or business

FATHER
12. Name: James Dye
13. Birthplace: Maryland

MOTHER
14. Maiden name: Sarah Miller
15. Birthplace: Maryland

16. Informant: Memorial Hospital
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 11. 1939 (month) (day) (year)
Cemetery or crematory: Dye Cemetary
Location: Lonaconing Md.

18. Funeral director: David L. Boal
Address: Lonaconing Md.

19. July 10 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

DR. F. WILSON

## MEDICAL CERTIFICATION

20. DATE OF DEATH: July 8, 1939, at 3:40 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 5 1939, to July 8 1939, and that I last saw h- im alive on July 8 1939.

| Immediate cause of death | DURATION |
|---|---|
| Pulmonary Embolism | |
| Due to Rupture of Duodenal Ulcer | |
| Due to Cholecystectomy | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings:
Of operations: rupture of duodenal ulcer, operation for inclusion of gall bladder & abscess
By autopsy:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: F. M. Wilson M.D. M. D. or other
Address: Lonaconing Md. Date signed 7-10-39

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WITHIN CORPORATE LIMITS.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(160)

06612

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:
Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days) 1 day

Stay in this community (yrs., or mos., or days) 1 day

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 717 N. Mechanic
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME**

Baby Boy Gellner

**3. (b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | xxxx |

B (b) Name of husband or wife

B(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 16, 1939

8. AGE:

| Years | Months | Days | If less than one day |
|---|---|---|---|
| x | x | 1 | hrs. min. |

9. Birthplace Cumberland, Allegany, Maryland
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Arthur F. Gellner

13. Birthplace Cumberland, Md.

MOTHER 14. Maiden name Edith MacKay

15. Birthplace Cleveland, Ohio

16. Informant Arthur F. Gellner

Address 717 N. Mechanic St. Cumberland Md.

17. Burial Date thereof July 18, 1939
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory S. S. Peter & Paul

Location Cumberland, Md

18. Funeral director J. C. Wolford

Address Cumberland, Maryland

19. July 17, 1939 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 17, 1939, at 1:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 16 1939, to July 17 1939, and that I last saw him alive on July 16 1939

Immediate cause of death

Premature birth (35 wks gestation) 7-16-39

Due to

Due to Caesarian Section for premature separation of placenta 7-16-39

Other conditions

(Include pregnancy within 3 months of death)

DURATION

Major findings:

Of operations

Of autopsy

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Arthur F. Jones M. D.
M. D. or other

Address 40 N. Liberty St Date signed 7-17-39

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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VS A15

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# STATE OF MARYLAND—CERTIFICATE OF DEATH

06613

**1. PLACE OF DEATH** (160-C)

County Allegany Registration Dist. No. 6

Village or City Westernport, Md. No. The Reeves Clinic St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

WITHIN CORPORATE LIMITS OF

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U.S. if of foreign birth? ... yrs. ... mos. ... ds.

**2. FULL NAME** Baby Girl Glenn If U. S. Veteran, specify WAR ...

(a) Residence: No. ... St., ... Ward. Lonaconing
(Usual place of abode) If nonresident give city or town and State

## PERSONAL AND STATISTICAL PARTICULARS

| 3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) |
|---|---|---|
| Female | White | Single |

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day, and year) July 26, 1939

| 7. AGE Years | Months | Days | If LESS than 1 day, ... hrs. or ... min. |
|---|---|---|---|
| | | one | |

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. ...

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. ...

10. Date deceased last worked at this occupation (month and year) ...

11. Total time (years) spent in this occupation ...

12. BIRTHPLACE (city or town) Westernport, Md.
(State or country)

FATHER

13. NAME Francis Glenn

14. BIRTHPLACE (city or town) Lonaconing, Md.
(State or country)

MOTHER

15. MAIDEN NAME Elizabeth Hadra Moses

16. BIRTHPLACE (city or town) Lonaconing, Md.
(State or country)

17. INFORMANT Francis Glenn
(Address) Lonaconing, Md.

18. BURIAL, CREMATION, OR REMOVAL
Place Lonaconing, Md. Date July 27, 1939

19. UNDERTAKER Francis Glenn
(Address) Lonaconing, Md.

20. FILED 7/27, 1939 J. Raymond Baker, M.D. Registrar

## MEDICAL CERTIFICATE OF DEATH

**21. DATE OF DEATH** July 27, 1939
(Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attended deceased from July 26, 1939 to July 27, 1939

I last saw her alive on July 27, 1939; death is said to have occurred on the date stated above, at 1:40P. m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

| | Date of onset |
|---|---|
| Prematurity | 7-26-39 |
| Intra Cranial Hemmorhage | 7-26-39 |

Other Contributory Causes of Importance:

Name of operation ... Date of ...

What test confirmad diagnosis? Clinical Was there an autopsy? No

23. If death wes due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? ... Date of Injury ..., 19...

Where did injury occur? ...
(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of Injury ...

Nature of injury ...

24. Was disease or injury in any way related to occupation of deceased? ...

If so, specify ...

(Signed) J. Raymond Baker M. D.

(Address) Westernport, Md

*If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.*

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

# UNITED STATES STANDARD CERTIFICATE OF DEATH

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as **at school** or at **home**. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and **own home** in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel**, etc. For a person who had no occupation whatever write **none.**

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver**, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill**, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer**, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist**, etc. Distinguish carefully between **retail merchants** and **wholesale merchants.** A person who sells goods should be called a **salesman** and not a clerk.

**Statement of cause of death.**—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

**Example I**

| The principal cause of death and related causes of importance were as follows: | Date of onset |
|---|---|
| *Arteriosclerosis* | *1915* |
| *Chronic interstitial nephritis* | *1921* |
| *Cerebral hemorrhage* | *July 5, 1927* |
| | |
| | |
| Other contributory causes of importance: | |
| *Gallstones* | *May 1, 1923* |
| | |
| | |

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**Example II**

| The principal cause of death and related causes of importance were as follows: | Date of onset |
|---|---|
| *Attack of epilepsy* | *1 week ago* |
| *Run over by street car* | *1 week ago* |
| *Peritonitis* | *3 days ago* |
| | |
| | |
| Other contributory causes of importance: | |
| *Gastroenteritis* | *1 year* |
| | |
| | |

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

WITHIN CORPORATE LIMITS.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (194-a)

06614

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County: Allegany

City or town: Cumberland.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany hospital

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Md County: ~~Allegany~~ Washington

City or town: Hagerstown Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 1025 West Wash St
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** Ann Elizabeth Glick

**3. (b) Social Security Number**

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Feb 5 1924

**8. AGE:** Years: 15 Months: 5 Days: 23 If less than one day ____ hrs. ____ min.

9. Birthplace: Cumberland Md
(Town, county, and state)

10. Usual occupation: School

11. Industry or business

FATHER
12. Name: Francis J Glick
13. Birthplace: Cumberland, Md

MOTHER
14. Maiden name: Helen R Weiseckel
15. Birthplace: Cumb. Md

16. Informant: Mrs Helen R Glick
Address: Hagerstown Md.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: Aug 1 34 (month) (day) (year)

Cemetery or crematory: Hagerstown

Location: Hagerstown Md

18. Funeral director: Lewis Stein Inc.

Address: Cumberland, Md.

19. July 30, 1939 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH: 7-28-39 19____, at ____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-26-39 19____, to ____ 19____, and that I last saw her alive on 7-28-39 19____.

Immediate cause of death: Collapsed l. lung — DURATION: 2 days

Due to: Bronchiectasis

Due to: Plug of mucus in Bronchus

Other conditions
(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE: C C Zimmerman
M. D. or other

Address ____ Date signed 7-29-39

(M) (I) (T)

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
AUG 7 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

06615

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County Allegany

City or town Cumberland (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 320 Grand Ave.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

**2. USUAL RESIDENCE (HOME) OF DECEASED:** (For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. 320 Grand Ave (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** Charles Vernon Hooton

**3. (b) Social Security Number**

4. Sex: male

5. Color or race: white

6. (a) Single, married, widowed, or divorced: married

6 (b) Name ~~of husband or~~ wife: Nelle L. Hooton

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): July 21 1876

**8. AGE:** Years: 62 Months: 10 Days: 11 If less than one day ____ hrs. ____ min.

9. Birthplace: Rowlesburg W. Va (Town, county, and state)

10. Usual occupation: Storehelper.

11. Industry or business: B. & O.

FATHER

12. Name: Joseph L Hooton

13. Birthplace: W Va.

MOTHER

14. Maiden name: Loretto Clark

15. Birthplace: Ohio

16. Informant: Nelle L Hooton

Address: 320 Grand Ave

17. Burial (Burial, cremation, or removal, Which?) Date thereof: July 5, 1939 (month) (day) (year)

Cemetery ~~or crematory~~: River View Cemetery

Location: Rowlesburg W Va.

18. Funeral director: Louis Stein Inc.

Address: 117 Frederick St.

19. July 3 1939 (Date rec'd by registrar) J. P. Franklin, M. D. Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH: 7-2 1939, at 9a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-2 1939, to 7-2 1939 and that I last saw h w alive on 7-2 1939

Immediate cause of death: Angina Pectoris — DURATION: 30 min

Due to: Arterio Sclerosis — 5 yrs.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy: no

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: no

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE: H. H. Gleason M.D. M. D. or other

Address: 126 Yuma Cumberland Date signed: 7/3/39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUL 13 1999
BUREAU V. S.

WITHIN CORPORATE LIMITS.

# MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore

Reg. Dist. No. 4

(34)

## CERTIFICATE OF DEATH

06616

**1. PLACE OF DEATH:**
(a) County: Allegany County
(b) City or town: Cumberland, Maryland (If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 3 days
(e) Length of stay in this community (yrs., mos., or days): 20 yr.

**2. HOME (USUAL RESIDENCE) OF DECEASED:**
(a) State: Maryland (b) County: Allegany County
(c) City or town: Cumberland (If outside city or town limits, write RURAL and give town)
(d) Street No.: 245 Offutt St. (If rural give location)
(e) If foreign born, how long in U. S. A.? ____ years

3 (a) FULL NAME: Nora Howdershell

3 (b) If veteran, name war:

3 (c) Social Security No.:

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: James R. Howdershell

6. (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) ~~XX~~ April 6, 1897

8. AGE: ~~50~~ Years: 42 | Months: 3 | Days: 19 | If less than one day: ____ hr. ____ min.

9. Birthplace: West Virginia (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: Own home

FATHER
12. Name: Ben Wolfe
13. Birthplace: West Virginia

MOTHER
14. Maiden Name: Alice Baldwin
15. Birthplace: West Virginia

16 (a) Informant: Memorial Hospital
(b) Address: Cumberland, Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 28, '39 (month) (day) (year)
(c) Cemetery or crematory: Olive Cemetery
Location: Moorefield, W. Va.

18 (a) Funeral director: Louis Stein, Inc.
(b) Address: Cumberland, Maryland

19 (a) July 27, 1939 (Date rec'd by registrar) (b) J. P. Franklin, M.D. Registrar

DR. R. WILLIAMS

## MEDICAL CERTIFICATION

20. Date of death July 25, 1939, at 10:55 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 12 19 39, to July 25 19 39 and that I last saw him alive on July 25 19 39

| Immediate cause of death | Duration |
|---|---|
| Cardiac Failure | |
| Due to Tertiary Syphilis | |
| Luetic Hepatitis | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy: Luetic Serosis Ascites

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Richard J. Williams MD (M. D. or other)
Address: 34 Vac Ave. Date signed 7/26/39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
AUG 7 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

# CERTIFICATE OF DEATH

210-m

06617

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County: Allegany

City or town: Cumberland, Md (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days): 15 hrs

Stay in this community (yrs., or mos., or days): 28 yrs

**2. USUAL RESIDENCE (HOME) OF DECEASED:** (For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Cumberland Ward No. 4 (If outside city or town limits, write RURAL NEAR and give town)

Street No. 216 Glen St (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: —

**3. (a) FULL NAME:** John William Johnson

**3. (b) Social Security Number:** 214-05-6591

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

B (b) Name of ~~husband~~ or wife: Virginia Frantz

6(c) If alive, give age: 22 years

7. Birth date of deceased (mo., day, yr.): Oct 28 - 1910

**8. AGE:** Years: 28 Months: 8 Days: 12 If less than one day: hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Truck Driver & Salesman

11. Industry or business: Retail Grocery & Meats

FATHER

12. Name: William Johnson

13. Birthplace: West Va

MOTHER

14. Maiden name: Betty Rutherford

15. Birthplace: West Va

16. Informant: Mrs Virginia Johnson

Address: Cumberland, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 13 - 39 (month) (day) (year)

Cemetery or ~~crematory~~: Greenmont

Location: Cumberland Md

18. Funeral director: V. L. Temperam

Address: Cumberland Md

19. July 12 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: July 10th 1939, at 10:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__, to ____ 19__, and that I last saw h____ alive on ____ 19__.

Immediate cause of death: Fractured skull

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations: no operation

Of autopsy: no autopsy

DURATION: 17 hours

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, ~~suicide, or homicide~~: accident Date of: 7-10-1939

Where did injury occur? near Cumberland, Allegany Md (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): Highway 40

Means of injury: automobile accident Injured at work? no

23. SIGNATURE: Lynne H. Corson, M.D. M. D. or other

Address: Cumberland, Md Date signed: 7-12-39

Deputy Medical Examiner - Allegany Co.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
AUG 7 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

# MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (75) WD

Reg. Dist. No. 4

## CERTIFICATE OF DEATH

06618

**1. PLACE OF DEATH:**
(a) County Allegany
(b) City or town Cumberland (If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: Allegany Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hr. 50 min
(e) Length of stay in this community (yrs., mos., or days) 2 hr. 50 min

**2. HOME (USUAL RESIDENCE) OF DECEASED:**
(a) State W. Va. (b) County Mineral
(c) City or town Elks Garden (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) If foreign born, how long in U. S. A.? years ✓

3 (a) **FULL NAME** Leo Joyce

3 (b) If veteran, name war: World War
3 (c) Social Security No.:
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife:
6. (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 7-10-1877
8. AGE: Years 42 Months Days 18 If less than one day hr. min.
9. Birthplace Elk Garden W Va (Town, county, and state)
10. Usual occupation Coal Miner
11. Industry or business Coal Mines
FATHER 12. Name John Joyce
13. Birthplace Ireland
MOTHER 14. Maiden Name Beatrice Keegan
15. Birthplace Ireland
16 (a) Informant Miss Adrienne Joyce
(b) Address Elk Garden W Va
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof aug 1 39 (month) (day) (year)
(c) Cemetery or crematory Catholic Cemetery
Location Keyser W Va
18 (a) Funeral director J. F. Sharpless
(b) Address Blaine W Va
19 (a) July 31 1939 (Date rec'd by registrar) (b) J. F. Franklin, M.D. Registrar

**MEDICAL CERTIFICATION**

20. Date of death July 29 1939, at 12:05 P M
21. I certify that death occurred on the date above stated; that I attended deceased from July 29 1939, to 19, and that I last saw him alive on July 29 1939.

| Immediate cause of death | Duration |
|---|---|
| Coma from 3 weeks of Glomerulonephritis | |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy no

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. Alfred Vaneman M. D. or other
Address Cumberland, Md. Date signed 7-31-39

VS. A15 PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

RECEIVED
AUG 7 1939
BUREAU V. S.

# STATE OF MARYLAND—CERTIFICATE OF DEATH

66619

V. S. No. 1

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

**1. PLACE OF DEATH** (930)

County Allegany — Registration Dist. No. 6

Village or City Westernport Maryland — No. I54 Church St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

WITHIN CORPORATE LIMITS OF

Length of residence in city or town where death occurrad ..... yrs. ..... mos. ..... ds. How long in U. S. if of foreign birth? ..... yrs. ..... mos. ..... ds.

**2. FULL NAME** John Joseph Kenny — If U. S. Veteran, specify WAR .....

(a) Residence: No. I54 Church St., Ward. .....

(Usual place of abode) — If nonresident give city or town and State

## PERSONAL AND STATISTICAL PARTICULARS

| 3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) |
|---|---|---|
| Male | White | Widowed |

5a. If married, widowed, or divorced — HUSBAND of (or) WIFE of: Mary V. Kenny

6. DATE OF BIRTH (month, day, and year): August I4. I859

| 7. AGE | Years | Months | Days | If LESS than 1 day, ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 79 | II | I5 | |

OCCUPATION

8. Trade, profession, or particular kind of work dona, as SPINNER, SAWYER, BOOKKEEPER, etc.: Retired

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.: X

10. Date deceased last worked et this occupation (month and year) .....

11. Total tima (years) spent in this occupation .....

12. BIRTHPLACE (city or town) (State or country): Ireland

FATHER

13. NAME: Richard Kenny

14. BIRTHPLACE (city or town) (State or country): Ireland

MOTHER

15. MAIDEN NAME: Bridget Collery

16. BIRTHPLACE (city or town) (State or country): Ireland

17. INFORMANT: James E. Kenny

(Address) Westernport, Md.

18. BURIAL, CREMATION, OR REMOVAL: St. Peters

Place Westernport Md Date July 3I, 1939

19. UNDERTAKER: Joseph A. Hannon

(Address) Westernport. Md.

20. FILED July 29, 1939 A J Baynbaker M.D. Registrar.

## MEDICAL CERTIFICATE OF DEATH

**21. DATE OF DEATH** July (Month) 29 (Day) 1939 (Year)

22. I HEREBY CERTIFY, That I attended deceased from Dec 21, 1938, to July 29, 1939

I last saw him alive on July 26, 1939; death is said to have occurred on the date stated above, at 4:15 P.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

| | Data of onset |
|---|---|
| Arteriosclerosis | Unknown |
| Asthma & Myocarditis | 1930 |
| Gastric Ulcer | 1937 |
| Other Contributary Causes of Importance: Cardiac Decompensation | 7/15-1939 |

Name of operation ..... Date of .....

What test confirmed diagnosis? None Was thara an autopsy? NO

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ....., 19.....

Where did injury occur? .....

(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of Injury .....

Nature of Injury .....

24. Was diseasa or Injury in any way related to occupation of deceased? NO

If so, specify .....

(Signed) A J Baynbaker M. D.

(Address) Westernport Md

*If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.*

# UNITED STATES STANDARD CERTIFICATE OF DEATH

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

**Statement of cause of death.**—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

| Example I | | Example II | |
|---|---|---|---|
| The principal cause of death and related causes of importance were as follows: | Date of onset | The principal cause of death and related causes of importance were as follows: | Date of onset |
| *Arterioselerosis* | *1915* | *Attack of epilepsy* | *1 week ago* |
| *Chronic interstitial nephritis* | *1921* | *Run over by street car* | *1 week ago* |
| *Cerebral hemorrhage* | *July 5, 1927* | *Peritonitis* | *3 days ago* |
| | | | |
| | | | |
| Other contributory causes of importance: | | Other contributory causes of importance: | |
| *Gallstones* | *May 1, 1923* | *Gastroenteritis* | *1 year* |
| | | | |
| | | | |

RECEIVED
AUG 2 1928
BUREAU V. S.

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

WITHIN CORPORATE LIMITS.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06620

(95-C)

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 202 Virginia Ave.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Cumberland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 202 Virginia Ave.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** Christina Jane Lathrum

**3. (b) Social Security Number**

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Robert Lathrum

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Jan 4 1864

**8. AGE:** Years 75 | Months 5 | Days 27 | If less than one day ____ hrs. ____ min.

9. Birthplace: Oakland Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: at Home

FATHER

12. Name: George L. Gauer

13. Birthplace: Md.

MOTHER

14. Maiden name: Rachael Sell

15. Birthplace: Md.

16. Informant: Robert Lathrum

Address: Cumberland

17. Burial (Burial, cremation, or removal, Which?) Date thereof July 3 '39 (month) (day) (year)

Cemetery or crematory: Hillcrest Cem.

Location: Cumberland

18. Funeral director: Louis Stein Inc.

Address: Cumberland

19. July 3 1939 (Date rec'd by registrar) Joseph P. Franklin, M.D. Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH July 1 1939, at 2:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 29 1939, to July 1 1939, and that I last saw her alive on July 1 1939.

Immediate cause of death: Coronary Occlusion

Due to: Myocarditis (Chronic)

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

DURATION: July 1 1939 about 1736

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: No Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: M E B Owens M. D. or other

Address: 133 Va Ave Date signed: July 1 39.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M E Owens

RECEIVED
AUG 7 1939
BUREAU V. S.

Outside of City Limits

CORPORATE LIMITS

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(946)

06621

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

(M)

**1. PLACE OF DEATH:**

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Celanese Plant

Stay in hospital or inst. (yrs., or mos., or days): --

Stay in this community (yrs., or mos., or days): 15 years

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 939 Braddock Road
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: ---

**3. (a) FULL NAME:** THOMAS LECLEAR

**3. (b) Social Security Number:** 214-07-1671

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Virginia B. Horn Berger

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): November 25, 1876

8. AGE: Years 62 | Months 7 | Days 29 | If less than one day ____ hrs. ____ min.

9. Birthplace: St. Louis, Missouri
(Town, county, and state)

10. Usual occupation: Chemist

11. Industry or business: Celanese

FATHER
12. Name: Louis R. LeClair
13. Birthplace: New York

MOTHER
14. Maiden name: Minnie Wells
15. Birthplace: South Carolina

16. Informant: Mrs. Virginia LeClear
Address: Cumberland, Maryland

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: July 27, 1939 (month) (day) (year)

Cemetery or crematory: Hillside Cemetery

Location: Rutherford, New Jersey

18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Maryland

19. July 26 1939 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

Dr. Zimmerman

### MEDICAL CERTIFICATION

20. DATE OF DEATH: July 24, 1939, at ____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-15-38 19__, to 7-24- 1939, and that I last saw him alive on 7-23-39 19__.

Immediate cause of death: Angina Pectoris — DURATION: 1 hr.

Due to: -

Due to: -

Other conditions: None
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide ____ Date of ____
Where did injury occur? ____ (City or town) ____ (County) ____ (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury ____ Injured at work?

23. SIGNATURE: [signature] Zimmerman
M. D. or other
Address: Cumberland Md. Date signed: 7-25-39

(I)

(X)

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
AUG 7 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(159)

06622

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hosp.

Stay in hospital or inst. (yrs., or mos., or days): 18Da.

Stay in this community (yrs., or mos., or days):

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland R.D. Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME:** Baby Boy Lewis

**3. (b) Social Security Number:**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Infant |

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): June 22, 1939

8. AGE: Years | Months | Days: 18 | If less than one day: hrs. min.

9. Birthplace: Cumberland, Md. (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER — 12. Name: Joseph Lewis

13. Birthplace: Cumberland

MOTHER — 14. Maiden name: Mary Keenan

15. Birthplace: Deer Park, Md.

16. Informant: Joseph Lewis

Address: Gen. Del. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 12, 1939 (month) (day) (year)

Cemetery or crematory: Mt. Nebow Cem.

Location: Near Deer Park, Md.

18. Funeral director: J. C. Wolford

Address: Cumberland, Md.

19. July 11, 39 (Date rec'd by registrar) J. F. Franklin, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: July 11, 1939, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 22 1939 to July 11 1939, and that I last saw h- -in- alive on July 10 1939

Immediate cause of death: Convulsion

Due to: Premature birth 7 mos. 2 1/4 lbs. complete

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

DURATION

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Allen G. Mann Jr. M.D. or other

Address: 41 Emmes St Cumberland Date signed: July 11 39

---

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
AUG 7 1939
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore

Reg. Dist. No. 06623

## CERTIFICATE OF DEATH

9

**1. PLACE OF DEATH:**
(a) County Allegany
(b) City or town Frostburg, Md. (If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution 321 Welsh Hill
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in this community (yrs., mos., or days) 56

**2. HOME (USUAL RESIDENCE) OF DECEASED:**
(a) State Md. (b) County Allegany
(c) City or town Frostburg (If outside city or town limits, write RURAL and give town)
(d) Street No. 321 Welsh Hill (If rural give location)
(e) If foreign born, how long in U. S. A.? _____ years

3 (a) **FULL NAME** Henry Lloyd

3 (b) If veteran, name war —

3 (c) Social Security No. 214-01-6658

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Anna May

6. (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) Aug. 20 1883

8. AGE: Years 56 | Months 10 | Days 22 | If less than one day _____ hr. _____ min.

9. Birthplace Frostburg Md. (Town, county, and state)

10. Usual occupation Miner

11. Industry or business Coal mines

FATHER
12. Name Henry Lloyd
13. Birthplace Wales

MOTHER
14. Maiden Name Margaret Davis
15. Birthplace Wales

16 (a) Informant Mrs. Walter Bradley
(b) Address Lonaconing, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-14-39 (month) (day) (year)
(c) Cemetery or crematory Cemetery
Location Frostburg

18 (a) Funeral director J. J. Kenny
(b) Address Frostburg Md.

19 (a) 7-13-39 (Date rec'd by registrar) (b) mo. A. R. Walker Registrar

### MEDICAL CERTIFICATION

20. Date of death July 11 1939, at 10:40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 7 1939, to July 11 1939, and that I last saw him alive on July 11 1939.

| | Duration |
|---|---|
| Immediate cause of death: Chronic glomerular nephritis | 2 months |
| Due to: Bronchial asthma | 5 months |
| Due to: Myocarditis | months |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings:
Of operations —
Of autopsy —

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence —
(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)
(d) Did injury occur about home, on farm, industrial place, in public place? _____ (Specify type of place) While at work? _____
(e) Means of injury _____

23. Signature W. C. Diehl, M. D. (M. D. or other)
Address Frostburg, Md. Date signed 7-11-39.

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
AUG 2 19[illegible]
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131)

06624

## CERTIFICATE OF DEATH

Reg. Dist. No. 8

Lonaconing Md.

**1. PLACE OF DEATH:**

County Allegany

City or town Lonaconing Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital or institution: 43 Douglas Avenue

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 36 yrs. 4 mos. 13 days

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State Md. County All.

City or town Lonaconing Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 45 Douglas Ave.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR None

**3. (a) FULL NAME** Hannah Jones Lore

**3. (b) Social Security Number** None.

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Divorced |

6 (b) Name of husband or wife Daniel Brown

6(c) If alive, give age 39 years

7. Birth date of deceased (mo., day, yr.) Feb. 19. 1903.

**8. AGE:**

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 36. | 4. | 13. | ____hrs. ____min. |

9. Birthplace Lonaconing Md.
(Town, county, and state)

10. Usual occupation Stenographer

11. Industry or business Social Security

FATHER
12. Name Hugh Lore

13. Birthplace Lonaconing Md.

MOTHER
14. Maiden name Mary Muir

15. Birthplace Iowa

16. Informant James H. Lore
Address Berrgville Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 5. 1939 (month) (day) (year)

Cemetery or crematory Rose Hill

Location Cumberland Md.

18. Funeral director David S. Boal

Address Lonaconing, Md.

19. July 5 39 Dr. E. Dan Tyler
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 2 1939, at 2 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 2 1939 to July 2 1939

and that I last saw h alive on July 2 1939

| | DURATION |
|---|---|
| Immediate cause of death Uremia | |
| Due to Hypertension | |
| Chr. Nephritis | |
| Due to Myocarditis acute | 4/3/39 |
| Pepi Condition | |
| Other conditions | |

(Include pregnancy within 8 months of death)

Major findings:

Of operations

Of autopsy

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE L. L. Reames M.D.
M. D. or other

Address Westernport Md. Date signed 7/2/39

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
AUG 7 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 27-L

## CERTIFICATE OF DEATH

06625

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days) 6 months

Stay in this community (yrs., or mos., or days) life

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 320 Frederick St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** Joseph Albert Lytle

**3. (b) Social Security Number** 214-05-8061

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| M | Negro | single |

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 5, 1919

8. AGE:

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 19 | 10 | 26 | hrs. min. |

9. Birthplace Cumberland, Allegany Co. Md
(Town, county, and state)

10. Usual occupation Truck Driver.

11. Industry or business General Trucking

FATHER 12. Name Joseph Samuel Lytle

13. Birthplace Newberne, S.C.

MOTHER 14. Maiden name Viola Rhodes

15. Birthplace Cumberland, Md.

16. Informant Viola Lytle

Address 320 Frederick St.

17. Burial Date thereof Aug 7 1939
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Sumner Cemetery

Location Cumberland Md.

18. Funeral director Jacob Hofer

Address 230 Baltimore Ave.

19 Aug 1, 1939 J. P. Franklin, M.D.
(Date rec'd by Registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH July 31 1939, at 3.35 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 10 1939 to July 31 1939 and that I last saw h[illegible] alive on July 30 1939

| Immediate cause of death | DURATION |
|---|---|
| Peritonitis | |
| Due to | |
| Due to | |
| Other conditions Moderate obesity | |

(Include pregnancy within 3 months of death)

Major findings:

Of operations Abscess of Left Hip

Of autopsy

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide no Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — injured at work?

23. SIGNATURE J. J. Langston M. D. or other

Address 54 N. mechanic Date signed 8-1-39

RECEIVED
AUG 7 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

06626

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 431 Arch St.
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 27 yrs

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Md County: Allegany
City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 431 Arch St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

**3. (a) FULL NAME:** Harry C. Martin

**3. (b) Social Security Number:**

4. Sex: Male
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Married
B (b) Name of husband or wife: Helena Mattingly
6(c) If alive, give age: 48 years
7. Birth date of deceased (mo., day, yr.): Nov 18, 1882
8. AGE: Years: 56 Months: 7 Days: 9 If less than one day: hrs. min.
9. Birthplace: Bolivar, N.Y. (Town, county, and state)
10. Usual occupation: Druggist
11. Industry or business: Drug Store
FATHER 12. Name: Samuel G. Martin
13. Birthplace: Rome N.Y.
MOTHER 14. Maiden name: Alice Williams
15. Birthplace: Petrolia, Pa.
16. Informant: Mrs Harry Martin
Address: 431 Arch St.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 29, 1939 (month) (day) (year)
Cemetery or crematory: St. Peters & Paula Cem
Location: Cumberland, Md
18. Funeral director: Jacob Hafer
Address: Cumberland, Md.
July 28, 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: July 27 1939, at 3:45 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 20 1939, to July 27 1939, and that I last saw him alive on July 27 1939.

Immediate cause of death: Cerebral Apoplexy
Due to: Arterio Sclerosis.
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings:
Of operations:
Of autopsy:

DURATION: July 20

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: no Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: M. E. B. Owens M. D. or other
Address: 133 Va Ave Date signed: July 27 '39

M. E. B. Owens.

RECEIVED
AUG 7 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

06627

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County: Allegany
City or town: Cumberland (If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 321 Avirett Avenue
Stay in hospital or inst. (yrs., or mos., or days): ---
Stay in this community (yrs., or mos., or days): 30 years

**2. USUAL RESIDENCE (HOME) OF DECEASED:** (For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Ward No. (If outside city or town limits, write RURAL NEAR and give town)
Street No.: 321 Avirett Avenue (If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: ---

**3. (a) FULL NAME:** Reginald Shannon Martin

**3. (b) Social Security Number:**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| male | White | Married |

6 (b) Name of husband or wife: Lydia Devore
6(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): April 10, 1883

8. AGE: Years: 56 | Months: 2 | Days: 6 | If less than one day: ____ hrs. ____ min.

9. Birthplace: Hyndman, Pennsylvania (Town, county, and state)
10. Usual occupation: Conductor
11. Industry or business: Western Maryland R. R.

FATHER
12. Name: Benjamin Martin
13. Birthplace: Virginia

MOTHER
14. Maiden name: Mary Harrier
15. Birthplace: Virginia

16. Informant: Mrs. Martin, his wife
Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 10, 1939 (month) (day) (year)
Cemetery or crematory: Hillcrest Cemetery
Location: Cumberland, Maryland
18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Maryland

19. July 10 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: July 8 1939, at 11:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 28 1938, to July 8, 1939, and that I last saw h I M alive on July 8, 1939.

Immediate cause of death: Cancer of stomach — DURATION: 11/2 yrs

Due to: —

Due to: —

Other conditions: —

(Include pregnancy within 3 months of death)

Major findings:
Of operations: confirmed by x-ray.
Of autopsy:

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: — Injured at work?

23. SIGNATURE: Lysle R. Evenhart, M. D. M. D. or other
Address: 36 Greene St., Cumberland, Md. Date signed: 7/8/39.

RECEIVED
JUL 21 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

# CERTIFICATE OF DEATH

06628

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Memorial Hospital

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. OldTown Rd.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** Mrs. Susan Martin

**3. (b) Social Security Number**

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Widowed

B (b) Name of husband or wife: Natha Martin

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): August 27, 1861.

**8. AGE:** Years 77 | Months 10 | Days 9 | If less than one day ____ hrs. ____ min.

9. Birthplace: Pennsylvania
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business

FATHER
12. Name: James Smith
13. Birthplace: Penna.

MOTHER
14. Maiden name: Phoebe Hooper
15. Birthplace: Penna.

16. Informant: Memorial Hospital
Address: Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 8, 1939 (month) (day) (year)

Cemetery or crematory: Fairview Cem.

Location: Near Artemus Penna.

18. Funeral director: J. C. Wolford
Address: Cumberland, Md.

19. July 7 1939 (Date rec'd by registrar) J. R. Franklin, M.D. Registrar

## MEDICAL CERTIFICATION

A

20. DATE OF DEATH July 6, 1939 7:45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 5 1939, to July 6 1939, and that I last saw her alive on July 6 1939.

Immediate cause of death: Uterus Adenoma — DURATION 1934

Due to age

Due to Chronic Valvular heart disease — 1935

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE Mrs B Owens M. D. or other

Address 1337 Va — Date signed 7/7/39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
AUG 7 1939
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06629

107a

# CERTIFICATE OF DEATH

Reg. Dist. No. 7

**1. PLACE OF DEATH:**

County Allegany

City or town Barton, Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State Md County Allegany

City or town Barton, Md - Rural Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. ½ mile South of Barton
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Richard Elswood Michaels

3. (b) Social Security Number

4. Sex Male

5. Color or race White

6. (a) Single, married, widowed, or divorced ✓

6 (b) Name of husband or wife ✓

6(c) If alive, give age ✓ years

7. Birth date of deceased (mo., day, yr.) April 29, 1938

8. AGE: Years 1 Months 2 Days 13 If less than one day ____ hrs. ____ min.

9. Birthplace Barton, Allegany, Md.
(Town, county, and state)

10. Usual occupation ✓

11. Industry or business ✓

FATHER
12. Name Raymond Louis Michaels
13. Birthplace Franklin, Md.

MOTHER
14. Maiden name Marie C. Cornell
15. Birthplace Franklin, Md.

16. Informant Raymond Michaels
Address Barton, Md.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof July 14
(month) (day) (year)

Cemetery or crematory Morrisons

Location Reynolds, Md.

18. Funeral director D. D. Boal
Address Barton, Md.

19. July 13 1939 S. A. Boucher
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 12th 1939, at 10 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__, to ____ 19__,
and that I last saw h____ alive on ____ 19__.

Immediate cause of death Broncho-Pneumonia (Primary) — DURATION 5 days

Due to

Due to

Other conditions Malnutrition — 6 mos.

(Include pregnancy within 3 months of death)

Major findings:
Of operations no operation

Of autopsy no autopsy

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE Linnie H. Corson, M. D.
M. D. or other

Address Cumberland, Md. Date signed 9-12-1939

Deputy Medical Examiner Allegany Co.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
AUG 5 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

210-9

06630

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days) 12 hours

Stay in this community (yrs., or mos., or days)

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State W Va County Mineral

City or town near Ridgley R 1 W Va Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. Frankford Rd.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR ✓

**3. (a) FULL NAME** Katherine M. Miltenberger

**3. (b) Social Security Number**

| 4. Sex | 5. Color or race | 6. (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Single |

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 27 1938

**8. AGE:**

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 1 | 3 | 15 | hrs. min. |

9. Birthplace Cumberland Md

(Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER

12. Name James E. Miltenberger

13. Birthplace W. Va.

MOTHER

14. Maiden name Mary A. Rephann

15. Birthplace Md.

16. Informant Jas E. Miltenberger

Address R.F.D. Ridgley, W. Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 13 '39 (month) (day) (year)

Cemetery or crematory St. Peter & Pauls

Location Cumberland Md.

18. Funeral director Louis Stein Inc.

Address Cumberland

19. July 13 1939 (Date rec'd by registrar) Jos. B. Franklin M.D. Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH July 12 1939, at 6:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 12 1939, to July 12 1939, and that I last saw her alive on July 12 1939.

Immediate cause of death Chest and internal injuries crushed

Due to being run over by an automobile

Due to

Other conditions Shock

(Include pregnancy within 3 months of death)

Major findings:

Of operations none

Of autopsy none

DURATION 12 hours

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of July 12 39

Where did injury occur? Mineral (City or town) (County) W Va (State)

Injured at home, farm, industry, public place (where?) Farm home

Means of injury Automobile Injured at work?

23. SIGNATURE F. Alan G. Murray M.D. M. D. or other

Address 41 Green St Date signed July 13

Cumberland Md 39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
AUG 7 1939
BUREAU V. S.

Outside of City Limits

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

06631

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County: Allegany
City or town: Flintstone Md. R.F.D.2.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: —
Stay in hospital or inst. (yrs., or mos., or days): —
Stay in this community (yrs., or mos., or days): —

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Md. County: Allegany
City or town: Flintstone Md. Rural near Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: Flintstone Md. R.F.D.2.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: —

**3. (a) FULL NAME:** Stillborn Morgan

**3. (b) Social Security Number:** —

4. Sex: Fetus determinate
5. Color or race: W
6. (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: —
6(c) If alive, give age: — years
7. Birth date of deceased (mo., day, yr.): July 13, 1939
8. AGE: Years — Months — Days — If less than one day: — hrs. — min.
9. Birthplace: Flintstone Md. R.F.D.2. Allegany Co.
(Town, county, and state)
10. Usual occupation: —
11. Industry or business: —
FATHER
12. Name: Earl R. Morgan
13. Birthplace: Cumberland, Md.
MOTHER
14. Maiden name: Charlotte S. Miley
15. Birthplace: Cumberland Valley, Pa.
16. Informant: Mrs. Earl R. Morgan
Address: Flintstone, Md. R.F.D 2
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 13, 1939 (month) (day) (year)
Cemetery or crematory: At home
Location: Flintstone Md. R.F.D 2
18. Funeral director: Earl R. Morgan
Address: Flintstone Md. R.F.D 2
19. July 17 1939 (Date rec'd by registrar) Jos. B. Franklin M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: July 13 1939, at 7.35 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from — 19—, to — 19—, and that I last saw h— alive on — 19—.

| Immediate cause of death | DURATION |
|---|---|
| Still born | |
| Due to | |
| Due to | |
| Other conditions Poor health of mother | |

(Include pregnancy within 3 months of death)

Major findings:
Of operations: —
Of autopsy: —

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?) —
Means of injury — Injured at work?

23. SIGNATURE: J. A. Watson M.D.
M. D. or other
Address: Little Orleans, Md. Date signed: July 13, 1939

RECEIVED
AUG 7 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131)

## CERTIFICATE OF DEATH

06632

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital or institution: 80 Greene Street

Stay in hospital or inst. (yrs., or mos., or days) —

Stay in this community (yrs., or mos., or days) 60

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 80 Greene St
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR —

**3. (a) FULL NAME** Helena B. Morgan

**3. (b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Married |

6 (b) Name of husband or wife William L. Morgan

6(c) If alive, give age 78 years

7. Birth date of deceased (mo., day, yr.) Febr. 20, 1860

8. AGE: Years 78 | Months 9 | Days 14 | If less than one day — hrs. — min.

9. Birthplace Sheffield, England
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business —

FATHER 12. Name Jabez Bellamy

13. Birthplace England

MOTHER 14. Maiden name Sarah Tyson

15. Birthplace England

16. Informant Mrs. William L. Morgan

Address Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 4, 1939 (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Cumberland, Maryland

18. Funeral director Louis Steyer Sons

Address Cumberland, Maryland

19. July 4 1939 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 7-2-1939, at 9:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-12-1939, to 7-2-1939 and that I last saw h[illegible] alive on 7-1-1939.

| Immediate cause of death | DURATION |
|---|---|
| Chronic Nephritis (Uremia) | ? |
| Due to Chronic Myocarditis | |
| Due to Acute Endocarditis | |
| Other conditions Arteriosclerosis | |

(Include pregnancy within 3 months of death)

Major findings:

Of operations —

Of autopsy —

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work?

23. SIGNATURE Wm. L. Williams M. D. or other

Address Cumberland Date signed 7-3-39

RECEIVED
AUG 4 1939
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

## CERTIFICATE OF DEATH

06633

Reg. Dist. No. 6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**

County Allegany

City or town Westernport

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 72 Main Street

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Westernport, Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 72 Main Street

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** Edith Morrison

**3. (b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Single |

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 23, 1879

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 60 | 2 | 25 | hrs. min. |

9. Birthplace Alexandria, Virginia (Town, county, and state)

10. Usual occupation Nurse

11. Industry or business

FATHER 12. Name James Morrison

13. Birthplace Near Baltimore, Virginia

MOTHER 14. Maiden name Esther Rebecca Clark

15. Birthplace Alexandria, Virginia

16. Informant Martha Morrison

Address Westernport, Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 20, 1939 (month) (day) (year)

Cemetery or crematory Philos Cem.

Location Westernport, Md.

18. Funeral director D. A. Zaal

Address Easton, Md.

19. July 20 1939 (Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH July 18th, 1939, at 2:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 26 1938 to July 18 1939 and that I last saw h[illegible] alive on July 18 1939.

| | DURATION |
|---|---|
| Immediate cause of death Coronary Thrombosis | 2 yrs. |
| Due to | |
| Due to | |
| Other conditions Arthritis Chronic. | 6 mo. |

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert W. Beard M.D.

M. D. or other

Address Piedmont, W.Va. Date signed 7-20-39

RECEIVED
AUG 7 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (34)

## CERTIFICATE OF DEATH

06634

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

**1. PLACE OF DEATH:**

County: Allegany County

City or town: Cumberland, Maryland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Memorial Hospital

Stay in hospital or inst. (yrs., or mos., or days): 6 days

Stay in this community (yrs., or mos., or days):

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: West Virginia County: Hardy County

City or town: Moorefield Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Maine St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: ✓

**3. (a) FULL NAME:** Alice Murphy

**3. (b) Social Security Number:**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Single |

6 (b) Name of husband or wife: None

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 17, 1937

8. AGE:

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 1 | 20 8 | 14 | hrs. min. |

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: None

11. Industry or business: None

FATHER
12. Name: William Murphy
13. Birthplace: Frostburg, Md

MOTHER
14. Maiden name: Mary Strother
15. Birthplace: West Virginia

16. Informant: Memorial Hospital

Address

17. Burial-Removal (Burial, cremation, or removal. Which?) Date thereof: Aug 2 1939 (month) (day) (year)

Cemetery or crematory: Allegany Cem

Location: Frostburg Md

18. Funeral director: J. J. Durst.

Address: Frostburg Md

19. July 31, 19 39 (Date rec'd by registrar) J. H. Franklin M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: July 31 1939, at 7:23 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 24/39 19 to July 31 1939, and that I last saw h-er alive on July 31 1939.

Immediate cause of death: Encephalitis (Lethargica) — DURATION

Due to: Measles.

Due to: Bronchopneumonia

Due to: otitis Media.

Other conditions: Syphilis (congenital)

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Wright Reynolds M.D.
M. D. or other

Address: Cumberland Md. Date signed: July 31/39.

RECEIVED
AUG 7 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(183)

06635

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Found in Will's Creek
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 20 years

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 443 North Center St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

**3. (a) FULL NAME:** GLADYS VIE NEHRING

**3. (b) Social Security Number:** 217-10-6143

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Widowed |

6 (b) Name of husband or wife: Leo Nehring

6(c) If alive, give age: -- years

7. Birth date of deceased (mo., day, yr.): November 9, 1894

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 44 | 8 | 2 | hrs. min. |

9. Birthplace: Keyser West Virginia (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: at Home.

FATHER — 12. Name: Samuel Crawford

FATHER — 13. Birthplace: West Virginia

MOTHER — 14. Maiden name: Hattie Meyers

MOTHER — 15. Birthplace: West Virginia

16. Informant: Mrs. Allen J. Bender

Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal, Which?) Date thereof July 14 '39 (month) (day) (year)

Cemetery or crematory: Sts Peter & Pauls Cem.

Location: Cumberland

18. Funeral director: Louis Stein, Inc.

Address: Cumberland, Maryland

19. July 12 1939 (Date rec'd by registrar) Jos. B. Franklin M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: July 11th 1939, at about 3 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ---- 19---, to ---- 19---, and that I last saw h---- alive on ---- 19----.

| Immediate cause of death | DURATION |
|---|---|
| Probably accidental drowning | |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 8 months of death)

Major findings:

Of operations: —

Of autopsy: none

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, ~~suicide~~, or ~~homicide~~: Probably accident Date of 7-11-39

Where did injury occur? Cumberland Allegany Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?): Willis house

Means of injury: drowning Injured at work? no

23. SIGNATURE: Thomas H. Jonson, M.D.
M. D. or other

Address: Cumberland, Md. Date signed 7-11-39

Deputy Medical Examiner - Allegany Co.

RECEIVED
AUG 7 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS

# STATE OF MARYLAND—CERTIFICATE OF DEATH

06636

**1. PLACE OF DEATH** (131)

County Allegheny Registration Dist. No. 4

Village or City Cumberland No. Allegany Hospital St., 4-1 Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 71 yrs. 4 mos. 25 ds. How long in U.S. if of foreign birth? ..... yrs. ..... mos. ..... ds.

**2. FULL NAME** Henry W Obaker If U. S. Veteran, specify WAR .....

(a) Residence: No. Narrows Park St. Ward. .....

(Usual place of abode) If nonresident give city or town and State

## PERSONAL AND STATISTICAL PARTICULARS

| 3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) |
|---|---|---|
| Male | White | Widowed |

5e. If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Obaker

6. DATE OF BIRTH (month, day, and year) Feb 14 1861

| 7. AGE | Years | Months | Days | If LESS than 1 day, ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 78 | 4 | 25 | |

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Retired Carpenter

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. .....

10. Date deceased last worked at this occupation (month and year) ..... 11. Total time (years) spent in this occupation 45

12. BIRTHPLACE (city or town) Cumberland (State or country)

FATHER

13. NAME Henry Obaker

14. BIRTHPLACE (city or town) Germany (State or country)

MOTHER

15. MAIDEN NAME Elizabeth

16. BIRTHPLACE (city or town) Germany (State or country)

17. INFORMANT William Obaker (Address) Pittsburg Pa

18. BURIAL, ~~CREMATION~~, OR ~~REMOVAL~~ Place St Peter & Paul Date July 11, 1939

19. UNDERTAKER V. L. Lempereur (Address) Cumberland Md

20. FILED July 11, 1939 J. P. Franklin, Mr. Registrar.

## MEDICAL CERTIFICATE OF DEATH

**21. DATE OF DEATH** July (Month) 9 (Day), 1939 (Year)

22. I HEREBY CERTIFY, That I attended deceased from July 2, 1939, to July 9, 1939

I last saw him alive on July 9, 1939; death is said to have occurred on the date stated above, at 12:10 P.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

| | Date of onset |
|---|---|
| Uraemia | 3 days |
| Chronic Nephritis | [illegible] |
| Chronic Prostatitis | [illegible] |

Other Contributory Causes of importance:

| | |
|---|---|
| Acute Hepatogenic | |
| Jaundice | 10 days |

Name of operation ..... Date of .....

What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ....., 19....

Where did injury occur? ..... (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....

If so, specify .....

(Signed) [illegible] M. D.

(Address) 41 [illegible] St. Cumberland Md

*If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.*

MARGIN RESERVED FOR BINDING

N. B.—WRITE [redacted]LY, WITH UNFADING INK—THIS IS A PERMANENT RECO[redacted]ery item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

# UNITED STATES STANDARD CERTIFICATE OF DEATH

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

**Statement of cause of death.**—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

**Example I**

| The principal cause of death and related causes of importance were as follows: | Date of onset |
|---|---|
| *Arteriosclerosis* | *1915* |
| *Chronic interstitial nephritis* | *1921* |
| *Cerebral hemorrhage* | *July 5, 1927* |
| | |
| | |
| Other contributory causes of importance: | |
| *Gallstones* | *May 1, 1923* |
| | |
| | |

RECEIVED
AUG 7 1928
BUREAU V. S.

**Example II**

| The principal cause of death and related causes of importance were as follows: | Date of onset |
|---|---|
| *Attack of epilepsy* | *1 week ago* |
| *Run over by street car* | *1 week ago* |
| *Peritonitis* | *3 days ago* |
| | |
| | |
| Other contributory causes of importance: | |
| *Gastroenteritis* | *1 year* |
| | |
| | |

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

VS A15 (T) (I) MARGIN RESERVED FOR BINDING (M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95-2)

06637

## CERTIFICATE OF DEATH

Reg. Dist. No. 9

**1. PLACE OF DEATH:**

County: Allegany

City or town: Frostburg (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Miners Hospital

Stay in hospital or inst. (yrs., or mos., or days): 3 days

Stay in this community (yrs., or mos., or days): 18 years

**2. USUAL RESIDENCE (HOME) OF DECEASED:** (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Frostburg Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No.: McCullough Street (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: —

**3. (a) FULL NAME:** William A. Pearce

**3. (b) Social Security Number:** —

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Isabel Humphrey

6(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Dec. 6, 1864

**8. AGE:** Years: 74 Months: 7 Days: 1 If less than one day: hrs. min.

9. Birthplace: Barton, Md. (Town, county, and state)

10. Usual occupation: Blacksmith

11. Industry or business: Mine Shop

FATHER

12. Name: Thomas Pearce

13. Birthplace: England

MOTHER

14. Maiden name: Elizabeth Cowan

15. Birthplace: Eckhart, Md

16. Informant: Ethel Pearce

Address: Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 10, 1939 (month) (day) (year)

Cemetery or crematory: Allegany Cemetery

Location: Frostburg, Md.

18. Funeral director: M. Eichhorn

Address: Lonaconing, Md.

19. 7-10-39 1939 (Date rec'd by registrar) Mrs. A. R. Walton Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH: July 7 1939, at 7:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 30 1939, to July 7 1939, and that I last saw him alive on July 7 1939.

Immediate cause of death: Cerebral hemorrhage — DURATION: 7 days

Due to: arterio-sclerosis, hypertensive cardio-

Due to: vascular disease

Other conditions: (Include pregnancy within 3 months of death)

Major findings: —

Of operations: —

Of autopsy: —

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: H. C. Diehl, M.D. (M. D. or other)

Address: Frostburg, Md. Date signed: 7-7-39.

RECEIVED
AUG 2 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

(131)

06638

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County: MEMORIAL HOSPITAL
City or town: CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days): 6 days
Stay in this community (yrs., or mos., or days):

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 948 Gay Street
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: --

**3. (a) FULL NAME:** POOLE, WILLIAM MR.

**3. (b) Social Security Number:**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| MALE | WHITE | MARRIED |

6 (b) Name of husband or wife: ROBY, ANNIE — 6(c) If alive, give age: - years

7. Birth date of deceased (mo., day, yr.): X 1850 (Birthday unknown)

8. AGE: Years: 89 Months: ? Days: ? If less than one day: ____hrs. ____min.

9. Birthplace: W.VA. (Town, county, and state)

10. Usual occupation: UNEMPLOYED

11. Industry or business: Silk Mill

FATHER — 12. Name: UNKNOWN — 13. Birthplace:

MOTHER — 14. Maiden name: UNKNOWN — 15. Birthplace:

16. Informant: MEMORIAL HOSPITAL — Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 17, 1939 (month) (day) (year)
Cemetery or crematory: Davis Memorial Cemetery
Location: Cumberland, Maryland

18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Maryland

19. July 17 19 39 (Date rec'd by registrar) Jos. B. Franklin M.D. Registrar

DR. MATTHEWS

## MEDICAL CERTIFICATION

20. DATE OF DEATH: JULY 14, 1939, at 1:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 3 1939, to July 14 1939, and that I last saw h[illegible] alive on July 14 1939.

Immediate cause of death: Senile - Cardio-Vascular Renal disease — DURATION

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: 122 So Centre St Date signed:

RECEIVED
AUG 7 1939
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (186-a)

06639 9

## CERTIFICATE OF DEATH

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**

County Allegany

City or town Frostburg

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Miners Hospital

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Mt. Savage. Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR —

**3. (a) FULL NAME** George Edward Pratt

**3. (b) Social Security Number** 215-10-1190

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| male | White | Single |

6 (b) Name of husband or wife —

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 15th 1904

8. AGE:

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 35 | 0 | 13 | hrs. min. |

9. Birthplace Meyersdale, Penna. (Town, county, and state)

10. Usual occupation Fireman

11. Industry or business Brick Yard

FATHER 12. Name Frank P. Pratt

13. Birthplace Mt. Savage, Md.

MOTHER 14. Maiden name Anna Bordnick

15. Birthplace Mt. Savage, Md.

16. Informant James Pratt,

Address Portage, Penna. R.F.D.# 1

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 31st 1939 (month) (day) (year)

Cemetery or crematory St. Patricks

Location Mt. Savage

18. Funeral director J. J. Durst

Address Frostburg, Md.

19. 7-31 1939 (Date rec'd by registrar) Mrs. A. R. Walker Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 28th 1939, at 8 40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ——— 19—, to ——— 19—, and that I last saw h— alive on ——— 19—.

| | DURATION |
|---|---|
| Immediate cause of death Fractured Skull | |
| Due to fall on concrete steps in front of Majestic Theatre | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings:

Of operations Subdural Hemorrhage

Of autopsy None

**PHYSICIAN** Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide or homicide accident Date of July 27 '39

Where did injury occur? Mt. Savage, Allegany Co. Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Public place

Means of injury Fall Injured at work? no

23. SIGNATURE Prince H. Bosley, M.D. M. D. or other

Address Cumberland, Md. Date signed 7-29-39

Deputy Medical Examiner - Allegany Co.

RECEIVED
AUG 2 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS

Pryor

# MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore

Reg. Dist. No. 4

(210-M)

## CERTIFICATE OF DEATH

06640

**1. PLACE OF DEATH:**

(a) County Allegany

(b) City or town Cumberland (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: Allegany Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in this community (yrs., mos., or days) 19 yrs

**2. HOME (USUAL RESIDENCE) OF DECEASED:**

(a) State Maryland (b) County Allegany

(c) City or town Cumberland (If outside city or town limits, write RURAL and give town)

(d) Street No. 107 Mary Street (If rural give location)

(e) If foreign born, how long in U. S. A.? _____ years

3 (a) FULL NAME RUTH ALMA PRYOR

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife ---

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Aug. 2, 1919

8. AGE: Years 19 Months 11 Days 8 If less than one day _____ hr. _____ min.

9. Birthplace Cumberland, Allegany, Maryland (Town, county, and state)

10. Usual occupation Clerk

11. Industry or business N. Y. A.

FATHER

12. Name Jacob Pryor Maryland

13. Birthplace

MOTHER

14. Maiden Name Susan Bridenthaul

15. Birthplace Pennsylvania

16 (a) Informant Allegany Hospital

(b) Address Cumberland, Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 12, 39 (month) (day) (year)

(c) Cemetery or crematory Rose Hill Cemetery

Location Cumberland, Maryland

18 (a) Funeral director Louis Stein, Inc.

(b) Address Cumberland, Maryland

19 (a) July 11, 1939 (Date rec'd by registrar) (b) J. P. Franklin, M.D. Registrar

### MEDICAL CERTIFICATION

20. Date of death July 10th 1939 at 11.15 a.M

21. I certify that death occurred on the date above stated; that I attended deceased from _____ 19__, to _____ 19__, and that I last saw him alive on _____ 19__.

Immediate cause of death Laceration of brain, at base

Due to _____

Due to _____

Other conditions Punct. wound above left iliac crest. (Include pregnancy within 3 months of death)

Major findings:

Of operations none

Of autopsy none

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, ~~suicide, or homicide~~ accident

(b) Date of occurrence July 10th 1939

(c) Where did injury occur? near Cumberland, Allegany, Md. (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? Highway No. 40 (Specify type of place) While at work? no

(e) Means of injury automobile accident

23. Signature Lenne H. Corson, M.D. M. D. or other

Address Cumberland, Md. Date signed July 11th 39

Deputy Medical Examiner - Allegany Co.

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
AUG 7 1939
BUREAU Y. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (1154) Reg. Dist. No. 9

## CERTIFICATE OF DEATH

66641

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

**1. PLACE OF DEATH:**

(a) County Allegany.

(b) City or town Bowden Mines. (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: —

(d) Length of stay in hospital or inst. (yrs., mos., or days) —

(e) Length of stay in this community (yrs., mos., or days) 4 yrs.

**2. HOME (USUAL RESIDENCE) OF DECEASED:**

(a) State Md. (b) County Allegany.

(c) City or town Borden Mines. (If outside city or town limits, write RURAL and give town)

(d) Street No. — (If rural give location)

(e) If foreign born, how long in U. S. A.? — years

3 (a) **FULL NAME** Cecelia Melvina Rankin

3 (b) If veteran, name war —

3 (c) Social Security No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Child |

6 (b) Name of husband or wife —

6. (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct 24, 1933

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 5 | 8 | 13 | ____ hr. ____ min. |

9. Birthplace Frostburg Md. (Town, county, and state)

10. Usual occupation —

11. Industry or business —

FATHER 12. Name James Rankin

FATHER 13. Birthplace Zihlman, Md.

MOTHER 14. Maiden Name Mabel Gordon

MOTHER 15. Birthplace Frostburg Md.

16 (a) Informant Mrs. Orville Steele

16 (b) Address Frostburg, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 9, 1939 (month) (day) (year)

17 (c) Cemetery or crematory Allegany Cemetery

Location Frostburg Md.

18 (a) Funeral director Jacob Hafer

18 (b) Address Frostburg Md.

19 (a) 7-9-39 (Date rec'd by registrar) (b) mrs. A. R. Walker Registrar

**MEDICAL CERTIFICATION**

20. Date of death July 7 1939, at 12:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 13 1939, to July 7 1939 and that I last saw him alive on July 6 1939.

| Immediate cause of death | Duration |
|---|---|
| Septicemia | 24 days |
| Due to Abscess of Foot | 1 mo |
| Due to — | |
| Other conditions — | |

(Include pregnancy within 3 months of death)

Major findings:

Of operations —

Of autopsy —

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence —

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury —

23. Signature W. M. McLane Jr. M.D. (M. D. or other)

Address Frostburg Md. Date signed July 8 39

RECEIVED
AUG 2 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

27

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (82-a)

06642

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County Allegany

City or town Cumberland (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 71 Greene Street

Stay in hospital or inst. (yrs., or mos., or days) --

Stay in this community (yrs., or mos., or days) 61 years

**2. USUAL RESIDENCE (HOME) OF DECEASED:** (For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. 71 Greene Street (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR ---

3. (a) FULL NAME Theresa Elizabeth Reagan

3. (b) Social Security Number

4. Sex Female

5. Color or race White

6. (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife George A. Reagan

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) ~~[illegible]~~ Aug. 7, 1877

8. AGE: Years 61 Months 11 Days 0 If less than one day ____ hrs. ____ min.

9. Birthplace Cumberland, Allegany, Maryland (Town, county, and state)

10. Usual occupation Housewife at home

11. Industry or business ---

FATHER 12. Name Philipp McCall

13. Birthplace Ireland

MOTHER 14. Maiden name Anna Houck

15. Birthplace Maryland

16. Informant George A. Reagan

Address 71 Greene Street

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 10, '39 (month) (day) (year)

Cemetery or crematory St. Patrick's Cemetary

Location Cumberland, Maryland

18. Funeral director Louis Stein, Inc.

Address Cumberland, Maryland

19. July 10 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH July 7 1939, at 4 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1938, to July 7 1939, and that I last saw h[illegible] alive on July 6 1939

Immediate cause of death Cerebral Hemorrhage

Due to Hypertension

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE J. C. Eckfeld M. D. or other

Address Cumberland Date signed July 7-39

RECEIVED
AUG 7 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS

# MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore

Reg. Dist. No. 4

06643

## CERTIFICATE OF DEATH

**1. PLACE OF DEATH:**

(a) County ALLEGANY

(b) City or town CUMBERLAND (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: ALLEGANY

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in this community (yrs., mos., or days)

**2. HOME (USUAL RESIDENCE) OF DECEASED:**

(a) State MARYLAND (b) County ALLEGANY

(c) City or town CUMBERLAND (If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) If foreign born, how long in U. S. A.? years

3 (a) **FULL NAME** BABY REYNOLDS - MALE - Stillborn

3 (b) If veteran, name war

3 (c) Social Security No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Single. |

6 (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-21-39

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | | 0 hr. 0 min. |

9. Birthplace CUMBERLAND, MD (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name RUSSEL LEROY REYNOLDS

13. Birthplace CUMBERLAND, MD

MOTHER

14. Maiden Name VERA LOUISE STEVANUS

15. Birthplace BERLIN PA.

16 (a) Informant MRS. VERA REYNOLDS.

(b) Address 706 LAFAYETTE AVE

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 25 39 (month) (day) (year)

(c) Cemetery or crematory Allegany County

Location County Home

18 (a) Funeral director James Stimson

(b) Address Cumberland, Md.

19 (a) July 25 1939 J. Franklin, M.D. (Date received by registrar) Registrar

**MEDICAL CERTIFICATION**

20. Date of death 7-21 1939, at 8:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 21 1939, to July 21 1939 and that I last saw him alive on 19.

| Immediate cause of death | Duration |
|---|---|
| Premature (7½ months) | |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

**PHYSICIAN**

Underlins the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature James J. Johnson Jr. M. D. or other

Address Cumberland Md Date signed 7-22-39

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
AUG 7 1939
BUREAU V. S.

Outside of City Limits

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

(131) CB

06644

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**

County Allegany

City or town Cumberland (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Locust Grove

Stay in hospital or inst. (yrs., or mos., or days) 5 days

Stay in this community (yrs., or mos., or days) 5 days

**2. USUAL RESIDENCE (HOME) OF DECEASED.** (For newborn infants give residence of mother)

State Pa County Somerset

City or town Wellersburg Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR ✓

**3. (a) FULL NAME** Frederick O'Niel Robinette

**3. (b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | divorced |

6 (b) Name of husband or wife Bessie Butemarkle Robinette 6(c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) April 18, 1872

**8. AGE:** Years 67 | Months 2 | Days 29 | If less than one day ____ hrs. ____ min.

9. Birthplace Cheneysville Pa (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business Farm

FATHER 12. Name Amos Robinette

13. Birthplace Flintstone

MOTHER 14. Maiden name Rachael Dickens

15. Birthplace Cheneysville Pa

16. Informant Mrs Wm Poorbaugh

Address Locust Grove Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 19 1939 (month) (day) (year)

Cemetery or crematory Zion Lutheran Bedford Road

Location Cumberland Md

18. Funeral director Jacob Safley

Address Cumberland

19. 7-18 1939 (Date rec'd by registrar) Jos. B. Franklin MD Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH July 17 1939, at 11 25 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1939 to July 17 1939, and that I last saw h[illegible] alive on July 16 1939.

| Immediate cause of death | DURATION |
|---|---|
| Chronic Arteriosclerotic Heart Disease | 16 yrs. |
| Due to | |
| Due to | |
| Other conditions Chronic Nephritis. | 8 yrs. |

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John A. Logan M.D. M. D. or other

Address Lyndora, Pa Date signed 7-17-39.

RECEIVED
AUG 7 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (107-0) WITHIN CORPORATE LIMITS Reg. Dist. No. 9

# CERTIFICATE OF DEATH

WITHIN CORPORATE LIMITS 6645

**1. PLACE OF DEATH:**
(a) County Allegany
(b) City or town Cumberland (If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: Miners Hospital
(d) Length of stay in hospital or inst. (~~yrs., mos., or days~~) 1 hour
(e) Length of stay in this community (yrs., mos., or days)

**2. HOME (USUAL RESIDENCE) OF DECEASED**
(a) State Md. (b) County Garrett
(c) City or town Near Oakton (If outside city or town limits, write RURAL and give town)
(d) Street No. R. F. D. (If rural give location)
(e) If foreign born, how long in U. S. A.? ____ years

3 (a) **FULL NAME** Walter Odell Robinson

3 (b) If veteran, name war —
3 (c) Social Security No. ✓

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Child

6 (b) Name of husband or wife —

6. (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept 16-1932

8. AGE: Years 6 | Months 8 | Days 15 | If less than one day ____hr. ____min.

9. Birthplace Near Oakton (Town, county, and state)

10. Usual occupation School

11. Industry or business

FATHER
12. Name Bruce E. Robinson
13. Birthplace Garrett Co

MOTHER
14. Maiden Name Lida McKenzie
15. Birthplace Garrett Co

16 (a) Informant Mrs. Bruce Robinson
(b) Address R. F. D. Frostburg

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 5 1939 (month) (day) (year)
(c) Cemetery or crematory St. Louis
Location Near Oakton

18 (a) Funeral director J. J. Durst
(b) Address Frostburg

19 (a) 7-3-39 (Date rec'd by registrar) (b) Mrs. A. R. Mosher Registrar

## MEDICAL CERTIFICATION

20. Date of death 7/2 1939, at 7P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/26 1939, to 7/2 1939, and that I last saw him alive on 7/2 1939.

| Immediate cause of death | Duration |
|---|---|
| Broncho-Pneumonia | |
| Due to nr | |
| Due to nr | |
| Other conditions nr | |

(Include pregnancy within 3 months of death)

Major findings:
Of operations nr
Of autopsy nr

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide nr
(b) Date of occurrence nr
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? nr (Specify type of place) While at work? nr
(e) Means of injury nr

23. Signature Glen Kilday M D (M. D. or other)
Address 56 W. Main St Frostburg, Md Date signed 7/3/39

VS. A15 — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. — MARGIN RESERVED FOR BINDING

RECEIVED
AUG 3 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore

Reg. Dist. No. 4

# CERTIFICATE OF DEATH

06646

**1. PLACE OF DEATH:**

(a) County ALLEGANY

(b) City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: MEMORIAL HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3

(e) Length of stay in this community (yrs., mos., or days)

**2. HOME (USUAL RESIDENCE) OF DECEASED:**

(a) State MARYLAND County ALLEGANY

(c) City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give town)

(d) Street No. 822 SHAWNEE AVENUE, CITY
(If rural give location)

(e) If foreign born, how long in U. S. A.? _____ years

3 (a) **FULL NAME** HARRY D. SANNER

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex: MALE

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced: WIDOWED

6 (b) Name of husband or wife: ELIZABETH WESS SANNER

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) APRIL 5 1868

8. AGE: Years 71 | Months 3 | Days 4 | If less than one day _____ hr. _____ min.

9. Birthplace Baltimore MARYLAND
(Town, county, and state)

10. Usual occupation RETIRED

11. Industry or business Fish Merchant

FATHER 12. Name George (Howard) Sanner

FATHER 13. Birthplace U. S. A.

MOTHER 14. Maiden Name Unknown

MOTHER 15. Birthplace Unknown

16 (a) Informant MEMORIAL HOSPITAL

(b) Address Cumberland, Maryland

17 (a) Burial (Crypt) (Burial, cremation, or removal)

(b) Date thereof July 12, 1939 (month) (day) (year)

(c) Cemetery or crematory Rose Hill Cemetery

Location Cumberland, Maryland

18 (a) Funeral director Louis Stein, Inc.

(b) Address Cumberland, Maryland

19 (a) July 14 1939 (Date rec'd by registrar)

(b) J. P. Franklin, M.D. Registrar

## MEDICAL CERTIFICATION

20. Date of death JULY 9 19 39 at 3:07 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/16 19 39, to 7/9 19 39 and that I last saw him alive on 7/9/39 19

| Immediate cause of death | Duration |
|---|---|
| Chronic myocarditis | |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature J. H. Ruzumna M.D. M. D. or other

Address Cumberland Md Date signed 7/10/39

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
AUG 7 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(159)

06647

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County ALLEGANY

City or town CUMBERLAND (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: MEMORIAL HOSPITAL

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

**2. USUAL RESIDENCE (HOME) OF DECEASED:** (For newborn infants give residence of mother)

State MARYLAND County GARRETT

City or town OAKLAND Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: RUTH ANN SAVAGE

3. (b) Social Security Number

4. Sex: FEMALE

5. Color or race: WHITE

6. (a) Single, married, widowed, or divorced: SINGLE

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY 29, 1939

8. AGE: Years | Months 1 | Days 29 | If less than one day hrs. min.

9. Birthplace Rural - Oakland, MD. (Town, county, and state)

10. Usual occupation

11. Industry or business None

FATHER

12. Name WARD SAVAGE

13. Birthplace MARYLAND

MOTHER

14. Maiden name GERALDINE DeWITT

15. Birthplace MARYLAND

16. Informant Ward Savage

Address Oakland, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 30, 1939 (month) (day) (year)

Cemetery or crematory Oak Grove Cem

Location Near McHenry, Md

18. Funeral director W. W. Savage

Address Friendsville, Md

19. July 29 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH JULY 28 1939, at 5:40 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 22 1939, to July 29 1939, and that I last saw her alive on July 28 1939

Immediate cause of death: Premature Malnutrition

Due to Premature Burst

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings:

Of operations None

Of autopsy None

DURATION: May 29 1939

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. E. Ehrson M.D. M. D. or other

Address 126 Union St. Date signed 7/29/39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
AUG 7 1939
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

06648

Reg. Dist. No. 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**

County: Allegany

City or town: Lonaconing (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: The Leland

Stay in hospital or inst. (yrs., or mos., or days): —

Stay in this community (yrs., or mos., or days): 70 years

**2. USUAL RESIDENCE (HOME) OF DECEASED:** (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Lonaconing Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No.: The Leland (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: —

**3. (a) FULL NAME:** Jean McMillan Scott

**3. (b) Social Security Number:**

| 4. Sex | 5. Color or race | 6. (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Widow |

6 (b) Name of husband or wife: John Scott

6(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): April 28, 1857

8. AGE: Years: 82 | Months: 2 | Days: 9 | If less than one day: —hrs. —min.

9. Birthplace: New Lough, Va. (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: Home

FATHER 12. Name: Adam B. McMillan

FATHER 13. Birthplace: Scotland

MOTHER 14. Maiden name: Barbara Gordon

MOTHER 15. Birthplace: Scotland

16. Informant: John Scott

Address: Lonaconing Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 9, 1939 (month) (day) (year)

Cemetery or crematory: Philos Cemetery

Location: Westernport, Md

18. Funeral director: M. Eichhorn

Address: Lonaconing, Md

19. July 9 1939 (Date rec'd by registrar) D. E. Davis Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: July 7 1939, at 7 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1938, to June 7 1939, and that I last saw h— alive on July 6 1939

| Immediate cause of death | DURATION |
|---|---|
| Carcinoma of Uterus | |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

**PHYSICIAN** Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: — Injured at work?

23. SIGNATURE: Henry Dr. Hodgson M.D. M. D. or other

Address: Lonaconing, Md Date signed: July 8 39

RECEIVED
AUG 7 1939
BUREAU V. S.

Outside of City Limits

# STATE OF MARYLAND—CERTIFICATE OF DEATH

06649

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Any item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

## 1. PLACE OF DEATH

County Allegany — Registration Dist. No. 4

Village or City Cumberland — No. Bedford Road Route 3 St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

## 2. FULL NAME WILLIAM ANDREW SEIBERT — If U. S. Veteran, specify WAR

(a) Residence: No. Bedford Road, Route #3 St., Ward.

(Usual place of abode) — If nonresident give city or town and State

## PERSONAL AND STATISTICAL PARTICULARS

| 3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) |
|---|---|---|
| Male | White | Married |

5a. If married, widowed, or divorced — HUSBAND of (or) WIFE of: Mary M. Orndruff

6. DATE OF BIRTH (month, day, and year): April 4, 1867

| 7. AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 72 | 3 | 18 | |

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.: Railway work

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.: B. & O., retired

10. Date deceased last worked at this occupation (month and year): 12/31/38

11. Total time (years) spent in this occupation: 50 yr

12. BIRTHPLACE (city or town) (State or country): West Virginia

FATHER

13. NAME: Adam Seibert

14. BIRTHPLACE (city or town) (State or country): Germany

MOTHER

15. MAIDEN NAME: Unknown

16. BIRTHPLACE (city or town) (State or country): Unknown

17. INFORMANT (Address): William R. Seibert, Cumberland, Maryland

18. BURIAL, ~~CREMATION~~, OR ~~REMOVAL~~

Place: Greenmont Cemetery Date: July 24, 1939

19. UNDERTAKER: Louis Stein, Inc.

(Address): Cumberland, Maryland

20. FILED: July 24 1939 J. L. Franklin M.D. Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH: July 22, 1939 (Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attended deceased from 7-15-39, 19, to 7-22-39

I last saw h[illegible] alive on 7-21-39; death is said to have occurred on the date stated above, at 3 A.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

| | Date of onset |
|---|---|
| Pleurisy with effusion | |

Other Contributory Causes of Importance:

History influenza month ago

Name of operation: Date of:

Whet tast confirmed diagnosis? Thoracentesis Was there an autopsy? No

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of Injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether Injury occurred in INDUSTRY, In HOME, or in PUBLIC PLACE.

Manner of Injury

Nature of Injury

24. Wes disease or injury in any wey related to occupation of deceased? No

If so, specify

(Signed) W. Alfred Van Ormer M. D.

(Address) Cumberland, Md.

*If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.*

# UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and **own home** in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel,** etc. For a person who had no occupation whatever write **none.**

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver,** etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill,** etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer,** etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist,** etc. Distinguish carefully between **retail merchants** and **wholesale merchants.** A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

**Example I**

| The principal cause of death and related causes of importance were as follows: | Date of onset |
|---|---|
| *Arteriosclerosis* | *1915* |
| *Chronic interstitial nephritis* | *1921* |
| *Cerebral hemorrhage* | *July 5, 1927* |
| | |
| | |
| Other contributory causes of importance: | |
| *Gallstones* | *May 1, 1923* |
| | |
| | |

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AUG 7 1933
BUREAU V. S.

**Example II**

| The principal cause of death and related causes of importance were as follows: | Date of onset |
|---|---|
| *Attack of epilepsy* | *1 week ago* |
| *Run over by street car* | *1 week ago* |
| *Peritonitis* | *3 days ago* |
| | |
| | |
| Other contributory causes of importance: | |
| *Gastroenteritis* | *1 year* |
| | |
| | |

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (194-B) Reg. Dist. No. 8

# CERTIFICATE OF DEATH

06650

**1. PLACE OF DEATH:**

(a) County Allegany

(b) City or town Lonaconing (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in this community (yrs., mos., or days)

**2. HOME (USUAL RESIDENCE) OF DECEASED:**

(a) State Md. (b) County Allegany

(c) City or town Lonaconing (If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Francis Thomas Serb

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-12-38

8. AGE: Years 1 Months 5 Days 7 If less than one day hr. min.

9. Birthplace Lonaconing, Md (Town, county, and state)

10. Usual occupation Infant

11. Industry or business

FATHER 12. Name Bernard Serb

13. Birthplace Ocean Md

MOTHER 14. Maiden Name Elma Virginia Easter

15. Birthplace Terra Alta, W. Va

16 (a) Informant Bernard Serb

(b) Address Lonaconing, Md

17 (a) (Burial, cremation, or removal) (b) Date thereof 7/21/39 (month) (day) (year)

(c) Cemetery or crematory

Location Midland Md.

18 (a) Funeral director Jacob Hafer

(b) Address Frostburg Md.

19 (a) July 20-1939 (Date rec'd by registrar) (b) Dr. E. Don Taylor Registrar

## MEDICAL CERTIFICATION

20. Date of death July 19 1939, at 7 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 17 1939, to July 19 1939, and that I last saw him alive on July 18 1939.

Immediate cause of death Malnutrition due to birth paralysis 3 primary

Due to cause unknown. C.W.G.R. Does not mean acute poliomyelitis or infantile paralysis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

Duration

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Henry M. Hodgson M.D. M. D. or other

Address Lonaconing, Md Date signed July 20 '39

VS. A15 (I) MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
AUG 7 1939
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore

Reg. Dist. No. 10

## CERTIFICATE OF DEATH

06651

**1. PLACE OF DEATH:**

(a) County Allegany County

(b) City or town Mt Savage (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in this community (yrs., mos., or days)

**2. HOME (USUAL RESIDENCE) OF DECEASED:**

(a) State / (b) County

(c) City or town Still Born (If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) If foreign born, how long in U. S. A.? years

3 (a) **FULL NAME** S Lafler

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 6, 1939

8. AGE: Years Still | Months Born | Days | If less than one day ____ hr. ____ min.

9. Birthplace Mt Savage Md. (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name John E Shaffer

13. Birthplace Williamsburg Pa.

MOTHER 14. Maiden Name Georgiana Wineburgner

15. Birthplace Mt Savage Md

16 (a) Informant Mrs Margaret Wineburgner

(b) Address Mt Savage Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 6 1939 (month) (day) (year)

(c) Cemetery or crematory Methodist

Location Mt Savage Md

18 (a) Funeral director Mrs Wineburgner Grandfather

(b) Address Mt Savage Md

19 (a) 7-6-1939 (Date rec'd by registrar) (b) H. J. Bostetter M. D. Local Registrar

**MEDICAL CERTIFICATION**

20. Date of death July 6 19 39, at 3.45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from ____ 19____, to ____ 19____, and that I last saw him alive on ____ 19____.

| Immediate cause of death | Still Born | Duration |
|---|---|---|
| Due to | Premature Birth | |
| Due to | | |
| Other conditions | | |

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature H. J. Bostetter M. D. (M. D. or other)

Address Mt Savage Md Date signed 7/6-1939

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
AUG 2 1939
BUREAU V. S.

06652

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(93-C)

## CERTIFICATE OF DEATH

Reg. Dist. No. 5

**1. PLACE OF DEATH:**

County Allegany

City or town Keyser R.F.D. #3
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Keyser R.F.D. #3 Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** Miss Thelma Irene Simpson

**3. (b) Social Security Number**

| 4. Sex | 5. Color or race | 6. (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | W | Single |

B (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 30, 1903

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 35 | 10 | 28 | hrs. min. |

9. Birthplace Richwood Nicholas W.Va.
(Town, county, and state)

10. Usual occupation School teacher

11. Industry or business

FATHER
12. Name Rezin H. Simpson
13. Birthplace W.Va.

MOTHER
14. Maiden name Sofia Feaster
15. Birthplace W.Va.

16. Informant Fred M. Simpson
Address Ridgeley W.Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 31 39 (month) (day) (year)

Cemetery or crematory Dawson

Location Keyser W. Va.

18. Funeral director Harvey H. Zeigler

Address Hyndman, Pa.

19. 7-29, 1939 (Date rec'd by registrar) M.V. Vincenti Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH July 28 1939, at 10:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1939, to July 28 1939, and that I last saw her alive on July 28 1939.

Immediate cause of death Cardiac Arthmy — DURATION

Due to Chronic Myocarditis — 7 yrs.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E. G. Courrier M.D.
M. D. or other

Address Keyser W.Va Date signed 7-29-39

VS A15 (T) (I) (M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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AUG 5 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

06653

# STATE OF MARYLAND—CERTIFICATE OF DEATH

Social Security

214-05-5630

**1. PLACE OF DEATH** (100)

County Allegany Registration Dist. No. 4

Village or City Cumberland No. 909 Maryland Avenue St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residance in city or town where death occurred 18 yrs. 7 mos. 13 ds. How long in U.S. if of foreign birth? yrs. mos. ds.

**2. FULL NAME** MARIE M. STEPPE If U. S. Veteran, specify WAR ---

(a) Residence: No. 909 Maryland Avenue St., Ward. ---

(Usual place of abode) If nonresident give city or town and State

## PERSONAL AND STATISTICAL PARTICULARS

| 3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) |
|---|---|---|
| Female | White | Single |

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ---

6. DATE OF BIRTH (month, day, and year) December 1, ~~1890~~ 1891

7. AGE Years 47 Months 7 Days 14 If LESS than 1 day, hrs. or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Clerk

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. Kelly-Springfield

10. Date deceased last worked at this occupation (month and year) July '39

11. Total time (years) spent in this occupation 15 yr

12. BIRTHPLACE (city or town) (State or country) Cumberland Maryland

FATHER

13. NAME Harman Steppe

14. BIRTHPLACE (city or town) (State or country) Maryland

MOTHER

15. MAIDEN NAME Ida Gordon

16. BIRTHPLACE (city or town) (State or country) Maryland

17. INFORMANT (Address) Mrs. Herman Steppe Cumberland, Md.

18. BURIAL, CREMATION, OR REMOVAL Place St. P. & P. Date July 18, 1939

19. UNDERTAKER (Address) Louis Stein, Inc. Cumb'd, Md

20. FILED July 18, 1939, Jos. P. Franklin M.D. Registrar.

## MEDICAL CERTIFICATE OF DEATH

**21. DATE OF DEATH** July (Month) 15 (Day) 1939 (Year)

22. I HEREBY CERTIFY, That I attended deceased from July 6, 1939, to July 15, 1939

I last saw her alive on July 15, 1939; death is said to have occurred on the date stated above, at 10.25 a.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

| | Date of onset |
|---|---|
| Pulmonary Embolism Resid | July 15 39 |

Other Contributory Causes of importance:

| | |
|---|---|
| Acute Phlebitis veins Left leg with Thrombosis Saphenous vein | July 15 39 |

Name of operation ---- Date of

What last confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of Injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of Injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? ---

If so, specify

(Signed) [signature] M. D.

(Address) 41 Green St Cumberland Md

*If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.*

V. S. No. 1

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# UNITED STATES STANDARD CERTIFICATE OF DEATH

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

**Statement of cause of death.**—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

**Example I**

| The principal cause of death and related causes of importance were as follows: | Date of onset |
|---|---|
| *Arteriosclerosis* | *1915* |
| *Chronic interstitial nephritis* | *1921* |
| *Cerebral hemorrhage* | *July 5, 1927* |
| | |
| | |
| **Other contributory causes of importance:** | |
| *Gallstones* | *May 1, 1923* |
| | |
| | |

RECEIVED AUG 7 1939 BUREAU V. S.

**Example II**

| The principal cause of death and related causes of importance were as follows: | Date of onset |
|---|---|
| *Attack of epilepsy* | *1 week ago* |
| *Run over by street car* | *1 week ago* |
| *Peritonitis* | *3 days ago* |
| | |
| | |
| **Other contributory causes of importance:** | |
| *Gastroenteritis* | *1 year* |
| | |
| | |

**ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN**

WITHIN CORPORATE LIMITS.

06654

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(159)

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County ALLEGANY

City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: MEMORIAL HOSPITAL

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town MIDLAND, MARYLAND Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME BABY ~~GIRL~~ BOY STEVENSON · Twin #1

3. (b) Social Security Number

4. Sex ~~FEMALE~~ MALE

5. Color or race WHITE

6. (a) Single, married, widowed, or divorced SINGLE

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 11, 1939 @ 8:30 PM

8. AGE: Years | Months | Days | If less than one day 2 hrs. min.

9. Birthplace MARYLAND
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name CECIL STEVENSON
13. Birthplace MARYLAND

MOTHER
14. Maiden name MILDRED ~~SPENCER~~ Sheeters
15. Birthplace PENNA.

16. Informant MEMORIAL HOSPITAL

Address CUMBERLAND, MD.

17. (Burial, cremation, or removal. Which?) Date thereof July 12, 1939 (month) (day) (year)

Cemetery or crematory Old Lonaconing Cem

Location Near Lonaconing, Md.

18. Funeral director Mr. Cecil Stevenson - Parent

Address Midland, Md.

19. July 12 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH JULY 11, 1939 10:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 , to JULY 11 1939, and that I last saw her alive on JULY 11, 1939 19

Immediate cause of death

Due to Prematurity 6½ mos Pregnancy

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. L. Owens MD
M. D. or other

Address Cumberland Md Date signed 7-12-39

DR. A. JONES

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Authorization Exchange sep see form filed under Owen and also see birth cert. filed. 7/11/39.

RECEIVED
AUG 7 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

## CERTIFICATE OF DEATH

06655

Reg. Dist. No. 4

**1. PLACE OF DEATH:**
County: ALLEGANY
City or town: CUMBERLAND, MD.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: MEMORIAL HOSPITAL
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days):

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: MARYLAND County: ALLEGANY
City or town: MIDLAND, MARYLAND Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME:** BABY ~~BOY~~ GIRL STEVENSON - Twin #2

**3. (b) Social Security Number:**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| FEMALE | WHITE | SINGLE |

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): JULY 11, 1939- 9:55 PM

8. AGE: Years | Months | Days | If less than one day: 1 hrs. min.

9. Birthplace: MARYLAND (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: CECIL STEVENSON
13. Birthplace: MARYLAND

MOTHER
14. Maiden name: Shertzer, MILDRED
15. Birthplace: PENNSYLVANIA

16. Informant: MEMORIAL HOSPITAL
Address: CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 12, 1939 (month) (day) (year)
Cemetery or crematory: Old Lonaconing Cem
Location: Near Lonaconing Md

18. Funeral director: Mr. Cecil Stevenson-Parent
Address: Middindy Md

19. July 12, 1939 (Date rec'd by registrar) J. L. Franklin, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: JULY 11, 1939 at 10:00 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1939, to JULY 11 1939
and that I last saw him alive on JULY 11, 1939

| Immediate cause of death | DURATION |
|---|---|
| Prematurely | |
| 6½ mos - Pregnancy | |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: C L Dunn M D (M. D. or other)
Address: Cumberland Md Date signed 7-12-39

DR. A. JONES

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
AUG 7 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS

06656

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

92a

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County Allegany

City or town Cumberland (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 30 Oak Street

Stay in hospital or inst. (yrs., or mos., or days) --

Stay in this community (yrs., or mos., or days) 50 years

**2. USUAL RESIDENCE (HOME) OF DECEASED:** (For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. 30 Oak Street (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Henry M. Teal

3. (b) Social Security Number: No 178

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Elizabeth Wagner

6(c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.): Dec. 11, 1861

8. AGE: Years 77 Months 6 Days 21 If less than one day ___ hrs. ___ min.

9. Birthplace: Port Jervis, N. Y. (Town, county, and state)

10. Usual occupation: Glassblower

11. Industry or business

FATHER

12. Name: Hamilton B. Teal

13. Birthplace: New York State

MOTHER

14. Maiden name: Mary M. Warner

15. Birthplace: New York State

16. Informant: Mrs. Joseph H. Griffin

Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 5, 1939 (month) (day) (year)

Cemetery or crematory: Hillcrest Cemetary

Location: Cumberland, Maryland

18. Funeral director: Louis Stein, Inc.

Address: Cumberland, Maryland

19. July 3, 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH July 2 1939, at 4:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 18 1936, to July 2 1939, and that I last saw him alive on July 21 1939.

Immediate cause of death: Arteriosclerosis

Due to

Due to: Chronic Valvular heart disease

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION: about 5 yrs. 4 yrs.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: no Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: M. B. Owens M. D. or other

Address: 133 Vine Date signed 7/5/39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

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JUL 17 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

# CERTIFICATE OF DEATH

06657

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Allegany Hospital
Stay in hospital or inst. (yrs. or mos., or days) 7 days
Stay in this community (yrs., or mos., or days) "

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infant give residence of mother)
State Maryland County Washington
City or town Hancock Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. Rural
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** Daniel Washington

**3. (b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | Colored | Single |

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 5, 1938

8. AGE: Years 0 | Months 7 | Days 16 | If less than one day hrs. min.

9. Birthplace Rural - Hancock, Md
(Town, county, and state)

10. Usual occupation Child

11. Industry or business

FATHER
12. Name Charles M. Washington
13. Birthplace Great Cacapon W. Va.

MOTHER
14. Maiden name Orintha Smith
15. Birthplace Washington Co. Md.

16. Informant Orintha Washington
Address Hancock, Md

17. Burial, cremation, or removal. Which? Burial Date thereof July 23, 1939 (month) (day) (year)
Cemetery or crematory Hancock Cem
Location Hancock, Md

18. Funeral director T. P. Jenkins
Address Hancock, Md

19. July 21, 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 21, 1939, 12:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 14 1939 to July 21 1939 and that I last saw him alive on July 2nd 1939.

Immediate cause of death Gastro-enteritis — DURATION

Due to

Due to

Other conditions Malnutrition

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Walter B. Johnson M. D. or other
Address Cumberland, Md Date signed 7-21-39

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AUG 7 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS

# MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore

Reg. Dist. No. 4

06658

## CERTIFICATE OF DEATH

(8)

**1. PLACE OF DEATH:**

(a) County Allegany

(b) City or town Cumberland (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: Allegany Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in this community (yrs., mos., or days)

**2. HOME (USUAL RESIDENCE) OF DECEASED:**

(a) State Md. (b) County Allegany

(c) City or town Ellerslie Md. (If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Baby Boy Wenrich (1st)

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 14, 1939

8. AGE: Years | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace Cumberland Md. (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name Elton Wenrich
13. Birthplace Md.

MOTHER
14. Maiden Name Ruth Bagley
15. Birthplace Pa.

16 (a) Informant Elton Wenrich
(b) Address Ellerslie Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7 (month) 15 (day) 39 (year)
(c) Cemetery or ~~crematory~~ Cook Mills
Location Penna.

18 (a) Funeral director Harvey H. Zeigler
(b) Address Hyndman Pa.

19 (a) July 15, 1939 (Date rec'd by registrar) (b) Jos. R. Frankley M.D. Registrar

### MEDICAL CERTIFICATION

20. Date of death July 14 1939, at 12:32 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 14 1939, to July 14 1939 ~~and that I last saw him alive on~~ 19

Immediate cause of death Stillborn

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

Duration

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature J. G. McLean M. D. or other

Address 122 Bedford Date signed 7-15-39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
AUG 7 1930
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (159) Reg. Dist. No.

# CERTIFICATE OF DEATH

06659

**1. PLACE OF DEATH:**
(a) County: Allegany
(b) City or town: Borden Mines (Rural) (If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days): 4 hrs
(e) Length of stay in this community (yrs., mos., or days): 4 hrs

**2. HOME (USUAL RESIDENCE) OF DECEASED:**
(a) State: Md (b) County: Alleg
(c) City or town: Borden Mines (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) **FULL NAME** Baby Winebrenner

3 (b) If veteran, name war:
3 (c) Social Security No.:

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Single |

6 (b) Name of husband or wife:
6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4 1939

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | | 4 hr. min. |

9. Birthplace: Borden Mines Md (Town, county, and state)
10. Usual occupation: Infant
11. Industry or business

FATHER
12. Name: Harry Winebrenner
13. Birthplace: Borden Mines

MOTHER
14. Maiden Name: Mary Gomez
15. Birthplace: Wellersburg Pa.

16 (a) Informant: Jas. Gomez
(b) Address: Borden Mines Md

17 (a) (Burial, cremation, or removal) (b) Date thereof 7-5 1939 (month) (day) (year)
(c) Cemetery or crematory: Home Lot
Location: Borden Mines Md

18 (a) Funeral director: James Gomez
(b) Address:

19 (a) 7-5-'39 (Date rec'd by registrar) (b) Mrs. A. R. Walker Registrar

## MEDICAL CERTIFICATION

20. Date of death July 4 1939, at 2.00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 4 1939, to July 4 1939, and that I last saw him alive on July 4 1939.

Immediate cause of death: Prematurity — Duration: 4 hrs
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

**PHYSICIAN**
Underlins the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence:
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: W. O. Lane M.D. (M. D. or other)
Address: Frostburg Md Date signed: July 5-39

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

RECEIVED
AUG 2 1939
BUREAU V. S.

Outside of City Limits

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (82a)

# CERTIFICATE OF DEATH

56660

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County Allegany

City or town Cresaptown Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: McMullan Blvd.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 10 yrs.

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State Md County Allegany

City or town Cresaptown Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. McMullan Blvd.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** Alice Elmira Winkelblech

**3. (b) Social Security Number**

4. Sex F

5. Color or race W

6. (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Jackson B. Winkelblech

6(c) If alive, give age 77 years

7. Birth date of deceased (mo., day, yr.) April 15, 1866.

**8. AGE:** Years 73 Months 3 Days 1 If less than one day ___ hrs. ___ min.

9. Birthplace Lewistownship-Union Co., Pa.
(Town, county and state)

10. Usual occupation Housewife

11. Industry or business at Home.

FATHER
12. Name Andrew Jackson Catherman
13. Birthplace Millmont, Pa.

MOTHER
14. Maiden name Mary Yeisley
15. Birthplace Millmont Pa.

16. Informant Mrs W. S. Fortney
Address Cresaptown Md

17. Burial Date thereof July 19, 1939
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Lewisburg Cem.

Location Lewisburg Pa

18. Funeral director Jacob Hofer

Address Cumberland

19. 7-18 1939 (Date rec'd by registrar) M. H. Wiemuts Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 16 1939, at 8P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 4th 1939, to July 16 1939, and that I last saw her alive on July 16 1939.

Immediate cause of death Cerebral Hemorrhage

Due to Hypertension

Due to

Other conditions Paralysis of Entire left side
(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION Since Feb 4 1939

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. L. Owens M.D.
M. D. or other

Address Cumberland Md Date signed July 18-39

VS A15 MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
AUG 5 1939
BUREAU V. S.

CORPORATE LIMITS.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

(93C)

06661

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County: Allegany
City or town: Cumberland (If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 36 Mary Street
Stay in hospital or inst. (yrs., or mos., or days): --
Stay in this community (yrs., or mos., or days): 50 years

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 36 Mary Street
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

**3. (a) FULL NAME:** Hester Ann Wortman

**3. (b) Social Security Number:**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | ~~Married~~ Widowed |

6 (b) Name of husband or wife: Ross Wortman
6(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): June 10, 1855

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 84 | 0 | 25 | ____ hrs. ____ min. |

9. Birthplace: Pennsylvania (Town, county, and state)
10. Usual occupation: Housewife at home
11. Industry or business:
FATHER 12. Name: James Minard
13. Birthplace: Pennsylvania
MOTHER 14. Maiden name: Maria Rankin
15. Birthplace: Pennsylvania
16. Informant: Erskin H. Wortman
Address: 36 Mary Street, Cumb'd, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 6, 1939 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Cumberland, Maryland
18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Maryland
19. July 6 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: July 4, 1939, at ____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 15, 1939 to July 4, 1939, and that I last saw her alive on July 4, 1939

| Immediate cause of death | DURATION |
|---|---|
| Generalized Arteriosclerosis | |
| Chronic Myocarditis | |
| Due to Cardiac Decompensation | 1 1939 |
| Due to Coronary Thrombosis | 7/3/39 |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Clay E. Burress M. D. or other
Address: 245 Virginia Date signed: July 5 1939

RECEIVED
AUG 7 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (131) Reg. Dist. No. 9

WITHIN CORPORATE LIMITS

# CERTIFICATE OF DEATH

06662

**1. PLACE OF DEATH:**

(a) County Allegany

(b) City or town Frostburg (If outside city or town limits, write RURAL and give town)

(c) Street address, ~~hospital~~, or ~~institution~~: 33 Hill St

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in this community (yrs., mos., or days) 57

**2. HOME (USUAL RESIDENCE) OF DECEASED:**

(a) State Md (b) County Allegany

(c) City or town Frostburg (If outside city or town limits, write RURAL and give town)

(d) Street No. 50 Mill St (If rural give location)

(e) If foreign born, how long in U. S. A.? — years

3 (a) FULL NAME Mary Jones Wright

3 (b) If veteran, name war —

3 (c) Social Security No. 220-10-2160

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or ~~wife~~ Geo. Wright

6. (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) Oct 14 - 1882

8. AGE: Years 57 Months 8 Days 19 If less than one day ____ hr. ____ min.

9. Birthplace Frostburg (Town, county, and state)

10. Usual occupation Seamstress W.P.A. Sewing

11. Industry or business

FATHER

12. Name David L. Jones

13. Birthplace Wales

MOTHER

14. Maiden Name Alice Lewis

15. Birthplace Wales

16 (a) Informant John Jones

(b) Address Frostburg Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-6-39 (month) (day) (year)

(c) Cemetery or crematory Cemetery Allegany

Location Frostburg

18 (a) Funeral director J. J. Hurst

(b) Address Frostburg

19 (a) 7-6-39 (Date rec'd by registrar) (b) Mrs. A. R. Walker Registrar

## MEDICAL CERTIFICATION

20. Date of death July 3 1939, at 4:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 18 1939, to July 3 1939, and that I last saw him alive on July 3 1939.

Immediate cause of death Chr Nephritis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

Duration ?

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Wm Lane Jr MD M. D. or other

Address Frostburg Md Date signed July 6 1939

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
AUG 2 1939
BUREAU V. S.

Outside of City Limits

06663

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

210-m

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County: Allegany

City or town: Near Cumberland (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Oldtown Road, on highway

Stay in hospital or inst. (yrs., or mos., or days): ---

Stay in this community (yrs., or mos., or days): 6 years

**2. USUAL RESIDENCE (HOME) OF DECEASED:** (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland Ward No.: (If outside city or town limits, write RURAL NEAR and give town)

Street No.: R. F. D. 4 (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: ---

**3. (a) FULL NAME:** JAMES EDGAR ZOLLNER

**3. (b) Social Security Number:**

| 4. Sex | 5. Color or race | 6. (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Single |

6 (b) Name of husband or wife: ---

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 25, 1933

**8. AGE:**

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 6 | 1 | 13 | hrs. min. |

9. Birthplace: Cumberland, Maryland (Town, county, and state)

10. Usual occupation: --- Student

11. Industry or business: ---

FATHER
12. Name: James W. Zollner
13. Birthplace: Cumberland, Md.

MOTHER
14. Maiden name: Fredericka Mitchell
15. Birthplace: Maryland

16. Informant: Memorial Hospital
Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 12, 1939 (month) (day) (year)

Cemetery or crematory: Mt. Herman Cemetery

Location: Cumberland, Maryland

18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Maryland

19. July 11, 1939 (Date rec'd by registrar) J. S. Franklin, M.D. Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH: July 8th 1939, at 7 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__, to ____ 19__, and that I last saw h__ alive on ____ 19__.

Immediate cause of death: Fractures of second and third cervical vertebrae.

Due to:

Due to:

Other conditions: Depressed fracture of occiput. (Include pregnancy within 3 months of death)

Major findings:

Of operations: none

Of autopsy: none

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, ~~suicide, or homicide~~: accident Date of: July 8th 39

Where did injury occur? near Cumberland (City or town) Allegany (County) Md (State)

Injured at home, farm, industry, public place (where?): Public Highway

Means of injury: struck by automobile Injured at work? no

23. SIGNATURE: Linnes H. Corson, M.D. M. D. or other

Address: Cumberland, Md. Date signed: July 10th 39

Deputy Medical Examiner - Allegany Co:

VS A15 (M) (I) (T) MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
AUG 7 1939
BUREAU V. S.